Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 Krishan Kaur 4:04 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery 5506 Ridgefield Road Bethesda 8. Date of Birth (Month, Day, Year) December 25, 1920 Age (In yrs. last birthday, **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Months 1 - M 2 X 579-84-0952 Hours Director 90 Tndia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter and once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 5506 Ridgefield Road United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Specify: Asian-Indian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oss Kaur Gurbachan Singh Sandhu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Satwant Singh Bajwa / Son 5506 Ridgefield Road, Bethesda, Maryland 20816 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. June 27, 2011 | Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. the gifts M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician: Hypertensive Renal Disease disease or condition resulting in death) Years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ctopic pregnancy
5 Other (specify) 4 Pregnant at time of death Month signed by the at d be detached for Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ours after death.

eral Director. After this certificate I filled in by the funeral director, pag performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To I Other: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number June 24, 2011 D09834

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DHMH 17 Rev 7/2009

State Registrar 3720 Farragut Avenue, Kensington, Maryland 20895-2110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Rosenbaum,

Barry N. R
31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fune Physician/ 3:30P. Rov H. Ladd Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗶 M 2 🗆 F Hours Feb 20 1920 New York 91 056-14-7241 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of the than "natural", or items 5.8 or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔯 No Severn Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1554 Severn Road 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian. Armed Forces? 1 Never Married 2X Married 1942 þ Yes Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyWhite 3 Widowed 4 Divorced 1945 Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Contract Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Clifford Varah Ladd Jennie Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Severn Road Severn, Maryland 21144 Roy H. Ladd, Jr., Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Durial 2 Dremation 3 Removal from State 06/29/11 Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License Thomas Gregor emation Society Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death
1 Natural
2 Accident 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pendina work? Accident 2 No neral Director: A Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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State

person who completed cause of death (Item 23a) (Type, Print)

301/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Charles Litzau July 20Ï1 7:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlestown Care Center Baltimore Catonsville 5. Social Security Number If Unde 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Maryland Months Hours April 6, 1922 215-12-1089 89 Director Usual Residence of Decedent show 10a. State 10d. Inside City Limits notified at 10c. City, Town or Location Director 28a-f Maryland Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r must be r ò Funeral 715 Maiden Choice Lane, Apt. CC611 21228 United States items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian other traumatic event, the Medical Examiner Armed Forces? WWII

1 Yes 2 No WWII

If Yes, Give Black, White, etc. ō 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 'natural", res, Give Year or Dates. '42-'45 White Completed 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Flactrics 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) 12 Electrical College (1-4 or 5+) NSA Superintendent Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Α. Litzau Nellie Read 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Tom Litzau / Son 405 Beachwood Ln., Bethany Beach, DE 19930 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or oth Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. | 07/02/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician a. Artorio Sclerotic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that littled as to the cause (Disease or linjury) Examine Due to for as a consequence of, burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Onknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death Check only one) Be examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catansville 32. Registrar's Signature

Registrar

0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O6 Physician/ 11:00PM Lancas Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOCHRAVEN 877 Conter 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day, 1 M 2 X Months Country Director Marvland 215-26-0229 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director 1 ☐ Yes 2X No Balto. Nottingham Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21236 USA 4122 Cliffvale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Elizabeth Chaffman Henry H. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 2318 Reckord Road Joppa, Md. 21085 Cindy Hooten 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1

Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial 7-1-2011 BelAir, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 21236 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Non Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the l IF FEMALE use yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months? Month Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar 29b. Signature and title of certifier

Mariam 31. Date filed (Month, Day, Year)

d address of person who completed cause of death (Item 23a) (Type, Print)

8 720

32. Registrar's Signature

R1502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death __Month Year Physician/ 7:30 AM 204 nam Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner A Innapolu Med ca If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D F Months Days Hours (Month, Day, Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State **Funeral Director** other traumatic event, the Medical Examiner must be notified 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? ō 23a 21060 "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Navu Specify: 3 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) eacher Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Print)

WHA Page Loc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Reproval from State b 16 4 Denation 5 Other (Specify) Signature of Funeral Service Unsee 22. Name and Address of Facility towell 4600 teights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ta disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter or denying Cause (Disease or iinjury that initiated events physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 1 Yes 2 L Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellity 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Tes Completed Vuscular Accelent 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No alon COUCTY 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 📈 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 5 Pending Natural 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Califying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 2480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMC Annopolis NO 31. Date filed (Month, Day, Year) gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 3 per doc g917 7-1-11 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. 3me3(Peath Physician/ Month 2¹4 201 1 ne Medical June 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster 8. Date of Birth (Month, Day, Year) 10-2-1909 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Min. 1 ☐ M 2**X** F Hours 213-38-5404 101 Director Usual Residence of Decedent s filed within 72 hours after death with the Maryland ital Hygiene.

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Carroll Westminster 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 250 St. Luke Circle, Apt.507 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: white 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file lith and Mental H 27 is marked of r traumatic ever ၉ Louise Sutter John A. Kanyuck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 7 2 0 1 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Louis J. Lerda-son 3250 Saint Andrews Dr., Chambersburg, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 7-2-2011 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home thein homas 254 E. Main St., Westminster, MD 21157 rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Day been signed by the should be detached 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 2 X No this certificate Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Hospita Other: 4 Nursing Home 읻 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at safter death. I **Director**: After the on by the fundera 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural
2 Accident injury work?
1 Yes 2 No 5 Pending 6 acacil found 2100 Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined Home To the Hospital within 24 hours aff 200 Nursina Medical Certifying Physician: To the best of my knowledge, down occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Months Day, Year) cause of death (Item 23a) (Type, Print) Hospital Center. arroll State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 500 M Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Health Services Montgomery Silver Spring 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 07 18 Country) 1 XM 2 □ 93 NY Director 114-12-5003 1917 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20905 609 Silverstone Ct. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 XYes 2 No Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1941-1946 1 Yes 2 XNo **Black** "natural", 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ntal Hygiene. ed other than " event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Station Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked ot ပ္ Carrie Brown George Leonard Lawrence Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Silverstone Ct. Silver Spring, MD 20905 Tony H. Lawrence, MD/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 06/29/2011 Brooklyn, NY The Evergreens Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Anderson Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Myocardial Infarction months disease or condition resulting in death) Medical Due to (or as a consequence of Examiner years Myocardiopathy Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of Exami years Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown detached g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Lung Disease 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24 hours after death.

Funeral Director: After this certificate has been sie eted filled in by the funeral director, page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? Ambulatory Dysfunction 24a. Was an autopsy performed' Dementia 1 ☐ Yes 2 🙀 No 1 Yes 2 K No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎛 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 K Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) To the within 2 d title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar

DHMH 17 Rev 7/2009

JE U I ZUII Z

Raman R. Tuli
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Darnestown Rd. Ste 202

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06/28/2011

Gaithersburg, MD 20878

11-04615	
Jacklyn Louden	

Jacklyn Louden		Flease Ty S - For State			nd / De	partm	ent of	Health and				20	Between states	21008		
Dhysisia		Registrar 1. Decedent's Name (First, Midd	lle Lest)			erunc	ate of I	Jealli		- 1:	Reg 2. Date of Death	g. No.		3. Time of Death		
Physician Medical Examin	-	Jacklyn Loud										Day Yea	r	0904 hrs		
		4a. Facility Name (if not instituti	on, give s		mber)		4b	. City, Town, or	Location o	f Death		4c. County of	of Death			
_		501 E. Preston Stree						Baltimore	T		Ta a constant	N/A	I a su	(0)		
Funeral Director	- 1	5. Social Security Number	6. Sex	- 1	7. Age (In y		thday)	If Under 1 Year Months Days		_			Foreign	nplace (State or		
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15-0 iled w Hygie		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)														
121 Id be f Aental	_	Jerome Jackson Vernell Louden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit											n State	Zin Code)		
2 shou and N	위	Betty Davis					-	•								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medical Injury or other transmatic event eve	ŀ	20a. Method of Disposition				Ob. Place	of Dispositi	Mt. Ho.	netery,		Date	20c. Location -	City or	Fown, State		
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Physician Medical	4	failure List only one cause on each line. Between C												Approximate Interval Between Onset and		
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	_	arcoti			Into	xicatio	n					Death		
	-		b.	e to (or as a	consequenc	se or).										
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Division of Vital Records, P.O. Box 68760, rs for Attending Physician: The law requires that the death certificate be rs after death. **I Director: After this certificate has been signed by the attending physicial in the funeral director, page 2 should be detached for use as the burities of the funeral director, page 2 should be detached for use as the burities.		IF FEMALE:	ha I	23c. If yes, o					Tatania			23d. Date of	-	Su. Year		
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cinn:	8	25. Was case referred to medic examiner?		pital: , 🗀 1					of Death (a au			
Physical directions	의	1 ✓ Yes 2 No 27. Manner of Death	1	28a. Date	npatient 2		outpatient Time of Inj		y at Work?		Home 5 F			Scene		
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Division of Vital Records, P.O. Box 6 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendic completely filled in by the funeral director, page 2 should be detached for use.	Medical		aı	n the basis on and manner st		on and/or	investigatio	n, in my opinion		curred at	the time, date a					
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140		 Name and address of perso Theodore M. King, Jr 		•	e of death (I nt Medica		niner 9	00 W. Baltim	nore Stre	eet. Ba	Itimore. MD	21223				
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FREDDY IRA LESSER Physician/ JUNE 28^{ay} 20 Î Î 8:28 Рм Medical 4c. County of Death BALTIMORE 4a. Facility Name (if not institution, give street and number)
GILCHRIST HOSPICE or Location of Death **Examiner** 4b. City, Town, TOWSON Social Security Number If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year **Funeral** 212-48-7175 1 🛛 M 2 🗆 F Months Days Min Country) 0873171945 MD Director 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10c. City. Town or Location **Funeral Director** BALTIMORE SPARKS MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21152 14203 QUAIL CREEK WAY Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CAREGIVER SPECIAL NEEDS Be 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ABEL LESSER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Sta 3731~GREENWAY~LANE, OWINGS MILLS, MD GARY LESSER/BROTHER 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARJ^{candi}Trin^{ato}TringiTeky CHIZUK AMUNO X Burial 2 Cremation 3 Removal from State 06/30/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Signature of Funeral Service Dicens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ metastatic 124.15 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by septic autimitic 2 No 3 Probably 4 onknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1100 Certificate: To 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28c. Injury at work? 1 🗌 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0070635 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Suite 4105 Baltimore, MD Zizo4 6701 N 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 29 12:43 AM 2011 Jeanne Anne Michel Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Month, Day, Year Dec 24, 79 Maryland Director 213-28-0230 1931 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21093 United States 12300 Rosslare Ridge Rd. Unit 305 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Black, White, etc. 2 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. "natural", Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Conrad Miller Matilda E. Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Mary Martha Michel /Daughter 11 Dorset Hill Ct. Owings Mills, MD 21117 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 9 Jun 30 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility 401585 Cremation and Funeral Alternatives heldecco 8717 Green Pastures Drive Towson Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner DAO VAS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a 1 Yes 2 9 Unknown ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d Describe how injury oc Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural
2 Accident
3 Suicide 5 Pending 6.24.2011 4:30 AM 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined House Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18215000 e 405, Baltimere, MD 21204

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ MISHOU Month 1929 OSEPIT MICHAEL M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 M 2 🗆 F Months Days Hours Min. Yrs. **Director** 214-60-3457 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at **Funeral Director** 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Anne Arundel Davidsonville 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3506 Mobile Ct. 21035 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural" 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chief Operating Officer Flooring traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mishou Harold Joseph Dowell Page 1 and 2 should be Virginia Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn A. Mishou / Wife 3506 Mobile Ct., Davidsonville, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4XXDonation 5 ☐ Other (Specify) Sers. Univ. 06/29/2011 Uniformed Bethesda, MD ²². Name and Address of Facility Rapp Funeral and Cremation Services envice Licensee 33 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line and cath Immediate Cause (Final Physician/ ATIC ALLUNE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CONTINUOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No Pregnant at time of death Month Day Year 9 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 -100 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar 29a Certifier

only one) 29b. Signature and title of certifi

Name and address of per-

HAEL 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Hospital

445

who completed cause of death (Item 23a) (Type, Print)

ENTA

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DEFENSE HWY

NNAPOLY MOZIYOI

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Annie ". 10 AM M MINOr 201 Medical 4a. Facility Name (if not institution, give street and number) 4c, County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Hopkins lohns Dayview If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Hours Min. July 26, Director 89 **T921** VA 212-44-0126 Usual Residence of Decedent fshow 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits ō Direct XXXes 2 No MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21213 USA **3928 Elmora Avenue** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 If Yes, Give 1 Yes 2XXNo Specify: "natural", Specify: Black 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Fleming Lucy Randolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important; If item 27 is any injury or other trau Theresa Minor/Daughter 392<u>8 Elmora Ave</u>. Baltimore, MD Baltimore, 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Cemetery 7-1-2011 | Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility James A. Morton & Sons F.H., Inc. 1701-31 Laurens St. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ intec OF decybitus ulcer tion disease or condition month Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No ed by the detached Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires ar demen. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 2 XNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director; A completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕏 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number $m\omega\omega$ 106262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

itophins Bay view Circle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2011 Jack Raleigh Mitchum Jr. 9:18 P M June 26 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 D F Months Days Hours Min. 1957 North Carolina **Director** 215-68-5571 54 May Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ems 23a or 28a-f short must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 2317 Chantaway Court USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. Ş 1 Never Married 2XXMarried ☐Yes 2X No "natural", or 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Electrical Estimator Electrical Company Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) item 27 is marked other traumatic ev မ 2011 Jack Ralaigh Mitchum Sr. Janet Marie Coverdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health ; 2317 Chantaway Ct., Bel Air, Maryland 21015 Charlotte C. Mitchum / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot JUNE 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 6-29-2011 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BRAIN CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Other (specify) Month Year To the Hospital or Attending Physician: The law requires that the deal within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown JACK MITCHUM Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title

JACKIE JONES,

31. Date filed (Month, Day, Year,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2300 DULANEY VALLEY RD.

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Day 30 Year Physician/ ELIZABETH MCDOWELL 3-10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CARROLL CENTER ARROLL WAITMINSTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 216-34-9207 Months Days Hours Min. 83 Director 27-1928 VA Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Carroll Finksburg 1 Yes 2 K No MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a USA Funeral 21048 1138 Ridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Force Black, White, etc. ö Completed by 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 27 is marked other than "natural", traumatic event, the Medical Exa If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nurse 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file h and Mental F 7 is marked of ၉ Mabel G. Kessinger Louis E. Mosley Department of Health an upportant: If item 27 is my injury or other 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1138 Ridge Rd., Finksburg, MD 21048 Elizabeth Ann Carbaugh Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State South Carroll Crem 7-1-2011 Sykesville, MD 4 Donation 5 Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home nemas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onșet and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ severe SEDSI disease or condition resulting in death) DA Medical Due to (or as a consequence of) Examiner DA Kenal Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examine Due to (or as a consequence DA NEARCTION attending physician and for use as the burial-transit MYOCARDIAL that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Grant
Pregnant at time of death in the past 12 months? Month Day Year ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed ral director, page 2 should be def 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No ဂ္ 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated з 🗆 29b. Signature and title of certifier 1065152 JUNE 200 MemoriAl ANO person who completed cause of death (Item 23a) (Type, Print) WESTMINITER 400 CARROLL HOSPITAL UTR

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia Iedical Examin	n/	Decedent's Name (First, Middl Richard	e,Last) Too	3d		Mart	in				Date of Dea Month June 17, 2	Day	Year	3. Time of Death 2024 hrs	
)		la. Facility Name (if not institution	n, give street and nu			4b.	City, To		cation of			4c. Cou	nty of Dea		
		7004 1/2 B Railway A		7. Age (In yrs	- Look binkbala	Dundalk day) If Under 1 Year If Under 24Hrs.					8 Date of Bir		irthplace (State or		
Funeral Director	1	5. Social Security Number 217–96–8278	6. Sex	7. Age (in yra	44	Yrs.	Months	Days	Hours	Min.		ry 4,19	F	^{ign} ountry)Marylan	d
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aryland Ba-f show at once.	Director	10e. Street and Number	-				10f. Zip C			-	11	0g. Citizen o		untry?	
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d be fenta	o Be	19a. Informant's Name/Relations									ıral Route Nu	mber, City or		te, Zip Code)	
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Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental Important: If item 27 is marked injury or other transmatic event,		20a. Method of Disposition 1 Burial 2 Crematio	n 3 Removal	rom State	crematory Bayvie	or othe	r place)		stery,	June 201	Date 22,		•	, Marylan	ıd
Baltimore, permit. Pages 1 an Department of He (important: If ite injury or other tr	ŀ	4 Donation 5 Other S 2 partial Donation 5 Other S	pecify: Licensee	0.0	-			-	of Facility		iome Qi	F Dund	- 11e	D 3	
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Division of Vital Records, P.O. Lat or Attending Physician: The law requires that the start death. **In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	ted b										24a. Was		24b. Were	autopsy findings av	ailable
Vital Records, stretch The law requirents to certificate has been director, page 2 should	Completed						_				auto	opsy formed? 2 No	prior t death		
II Re In: The Trificate for, pag		25. Was case referred to medic	al				2		of Death (Check c					
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ViSiC or Atter fter dear olrector	Certification:		estigation 28e. Pla	ace of Injury -	At home, farr	n, stree	t, factory,	office bu	uilding, etc	C.	28f. Location or Town,		lumber or	Rural Route Numbe	r, City
Di spital o hours al	Cert	4 Homicide	ermined (Specif					41					anner as s	tated	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Ex	Physician: To the basi	s of examinati	wiedge, deatr on and/or inv	n occum restigati	ed at the on, in my	opinion,	death occ	curred a	t the time, dat	e and place,	and due to	the cause(s)	_
7 % iv.	29b. Signature and title of certifier									signed (i	Month, Day, Year)				
		anel			(Itom 22 - \			O.C.N	/I.⊑.			Julie I	<u>, 2011</u>		
	Ų Ņ	30. Name and address of person Ana Rubio MD. As	on who completed ca ssistant Medica	l Examiner	900 W	. Balti	more S	treet, I	Baltimo	re, MD	21223				
S	tate	31. Date filed (Month, Day, Yea	32.	Registrar's Sig	gnature	J									

11-04514 Do

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nald	McLain		State of Maryland / De	partment of Certificate of		and	Menta	al Hyg		g. No. 2		1 2101	
	Physici		Registrar 1. Decedent's Name (First, Middle,Last)				_	2	Date of Deat	h	ear	3. Time of Death	
edica	al Exami	iner	Donald Lee McLain						June 16, 2	011		0110 hrs	
			 Facility Name (if not institution, give street and number) 1233 Darley Avenue 	4	b. City, Tov Baltimo		ocation of	Death		4c. County of Death ${ m N/A}$			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday)	If Under	1 Year	If Under :	24Hrs.	8. Date of Bir	h (MM/DD/YYY	Y) 9. Bir	thplace (State or	
	Director		215-68-4385 1 xm 2 F	53 Yrs.	Months	Days	Hours	Min.	11/25/1957 Foreign			gn puntry) MD	
			Usual Residence of Decedent										
	0W 2By		10a. State 10b. County 10c. C	ity, Town or Location	m alti	mor.	_					10d. Inside City Limits 1 X Yes 2 No	
	Maryland 28a-f show d at once.	ctor	10e. Street and Number	B	10f. Zip Co				10	Og. Citizen of V	/hat Cou		
	the Ma r or 24	Dire	1233 Darley Ave.		2	121	8			U.S.	Α.		
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath at Mantal Hygiene. The file of Pich was selected than "natural", or items 23a nr 28a-f shown it. If item 27a in narked other than "natural", or items 23a nr 28a-f shown in the traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Decedent				ify Yes or No-		e - Amer te, etc.	ican Indian, Black,	
	or deat	Fun	Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Yes 2 No. 3 XWidowed 4 Divorced If Yes, Giva Year	0	Yes 2				.,,		Bla	ck t	
	urs aft	d by	15. Decedent's Education (Specify only highest grade completed			-		nd of wor	k done	16b. Kind of B			
**	72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)		st of working	g life. D	NOT us	se retired	i)				
303	within iene. er tha Medic	Completed	12th Grade	War	ehou:					McCor		ks	
21215-0036	permit. Pages I and 2 should be filed within 72 hours after department of Health and Mental Hygien and Filem 27 in marked other than "natural", injury ar uther traumatic event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, Last) Marvin McLain			- 1			irst, Middle, N OYSCY	laiden Surnam	e)		
212	Ment:	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address					ber, City or To	wn, State	, Zip Code)	
8	d 2 sho th and a 27 is tumati		Marvin McLain(nephew)							ore, M			
ē,	t. Pages I and 2 sh tment of Health and rant: If item 27 is nr nther traumat		1 Burial 2 Cremation 3 Removal from State	b. Place of Disposit crematory or other	er place)				Date	20c. Location	- City or	Town, State	
Baltimore,	Pag ument rtant:		. Deliation of Gala. Specify.	erkley								on, MD	
E C	permit. Departs Import		21. Signeture of Funeral Service Licensee	が 2000 21	seph 40 n	idres of	『野野の ulto	wn n A	Jr. F ve.,	uneral Baltin	. Ho lore	me PA , MD21217	
	ysician		23a. Part I. Enter the disease, or complications thet caused the defailure. List only one cause on each line.	ath. Do not enter the	e mode of c	lying, su	ich as card	diac or re	espiratory arre	est, shock, or he		Approximate Interval Between Onset and	
	Medical aminer		Immediate Cause (Final disease a. Gastrointestinal Hem		licating 7	there	rtens	c-Card	iovascular	Disease		Death	
			or condition resulting in death) Due to (or as a consequence beginning to be	e of):									
		miner	if any, leading to immediate cause. Enter Underlying Cause	e of):									
	ed nsit	EX	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	e of):									
	te be executed ysician and burial - transit	edical	UNPENDED X AMENDED 23a,pe	er me,g92	2 12-	29-1	ll sm						
760,	ficate b g physi the bu		IF FEMALE: 23b. Was decedent pregnant in the			2 [C-tonia -			23d. Date o			
Box 6876	eath certificate attending phy for use as the	Physician/W	past 12 months?	death	al death er (Specify		Ectopic p	regnanc	у	Month		Day Year	
8	he deat the at hed for	hys	1 Yes 2 No 9 Unknown 9 Unknown						Loga Bidda			the cause of death?	
P.O.	res that t signed by be detac	Ď	Part II. Other significant conditions contributing to death but no chronic alcoholism	at resulting in the un	ideriying ca	iuse give	en in Part					pably 4 Unknown	
ds,	v require s been sig should b	eted							24a. Was a			topsy findings available	
Records,	e law r e has t ge 2 sh	Completed					_	_	autops perfor	med?	death?	completion of cause of	
= R	cian: The certificate ector, page		25. Was case referred to medical		26.	Place of	Death (C	heck onl		Z NO	1 🗸 Ye	es 2 No	
<u> </u>	hysicii this ce 1 direc	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	3 🔲 DOA	Ot	her ₄ N	lursing h	dome 5	Residence 6	✓ Other	r: Scene	
Division of Vital	ding P		27. Manner of Death 1 Natural 5 Pending	28b. Time of Inj			at Work?		d. Describe h	ow injury occur	red		
Sio	Atten r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - A	t home farm street					of Location (S	treet and Num	per or Ru	ıral Route Number, City	
<u>.</u>	Dapital or Atten hours after death ineral Director: y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	triomo, iaim, street	, raciory, or	noo ban	unig, otc.		or Town, S		oci oi ita	rai Nodio Nambor, Orly	
;	In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death. In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination										
·	8 14 € 14	Me	and manner stated. 29b. Signature and title of certifier		29c. L	icense r		DME		29d. Date sign	ned (Mo	nth, Day, Year)	
			Theodore M. King JR.	. m.).		C.M.	E.	C3985		June 16, 2	2011		
W			30. Name and address of person who completed cause of death (II Theodore M. King, Jr., MD. Assistant Medica		00 W P	altimo	re Stree	at Balt	imore MF	21223			
1	S1	ate	31. Date filed (Month, Day, Year) 32. R distrar's Sign	nature		aitiffio	is oliet	i, Dall	aniore, IVIL				
	Regist		1111 0 1 2011	A. bar	N. J								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner 4c. County of Death N/A 8. Date of Birth OCt. 24 If Under 1 Year Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛣 F 219-30-3905 Year) 933 Mary Land Director Usual Residence of Decedent 28a-f show 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Baltimore Parkville 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with and Mental Hygiene, is marked other than "natural", or items 23a 20 Delafield Court 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Produce Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Herdman Schwatka Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara J. Truluck Daughter 14 Delafield Court Parkville, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any Injury or or Diffraction of the place of the 4 ☐ Donation 5 ☐ Other (Specify) 7-1-2011 Timonium Maryland Ruck Towson Funeral Home, Towson, Maryland 21204 22. Name and Address of Facility 1050 York Road 23a. Part 1. Enter the disease, or complinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has it completed filled in by the funeral director, page 2.8 completed filled in by the funeral director, page 2.8 prior to completion of cause of death? performed? Yes 2 M N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20d Practicipated (Month, Play) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 063382 Laven 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 504

DHMH 17 Rev 7/2009

State Registrar The

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 2011 9:10 A M June Leon Joseph Niemiec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 4411 Westbrook Lane Kensington Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months (Month, Day, April ll 1 **X** M 2 □ F Hours **Director** <u>072-16</u>-6242 Yrs 1921 Massachusetts 90 Usual Residence of Decedent fshow 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f si notified 1 ☐ Yes 2 No Kensington Maryland Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral Page 1 and 2 should be filed within 72 hours after death with United States 20895 4411 Westbrook Lane iral", or items ? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 Widowed 4 Divorced WWII White ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Health Scientist Administrator Institute of Health 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Louise Sitnik Michael Joseph Niemiec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Westbrook Lane, Kensington, Maryland 20895 Pearl G. Niemiec Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemeter, cematory or other place)
Arlington
National Cemetery 1 X Burial 2 Cremation 3 Removal from State October 20, 4 Donation 5 Other (Specify) Arlington, Virginia 2011 21. Signature of Funeral Service Licensee Nobert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 12 Months Physician/ Cerebral Vascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Atrial Fibrillation 8 Years Sequentially list conditions, Days to (or as a consequence on cause. Enter Underlying Cause (Disease or iinjury Exami Coronary Artery Disease 8 Years sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 No ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Prolonged Immobility from Stroke cate has been signated by page 2 should by Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) June 27, 2011 D32610 man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McNamara, M.D. 10215 Fernwood Road #100, Bethesda, Maryland 20817 Thomas 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Page Not Found

Registrar DHMH 17 Rev 7/2009

State

Hospital

Medical

Natural Accident

Suicide

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

01

29a. Certifier

5 Pending Investigation

6 Could not be

Medical Examiner: On the ba

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

3 Certifying Nurse Practions

TABASSI

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

7601

work? 1 ☐ Yes 2 ☐ No

D46356

s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TOWSON,

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

OSLER DRIVE

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

21204

City or Town, State)

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 27^{ay} Lois M. Parks June 2011 3:45 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cockeysville 4c. County of Death
Baltimore **Examiner** 12416 Happy Hollow Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
May 26, 1923 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 213-20-0263 88 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location with the Maryland Director Cockeysville 1 Yes 2 No Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States of America 21030 Funeral 12416 Happy Hollow Road America and 2 should be filed within 72 hours after death Wealth and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: white 3 XWidowed 4 ☐ Divorced Completed Year or Dates Al Hygiene.
Jother than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Carefirst Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rachel Schurman Robert Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4845 Philadelphia Road Aberdeen, Maryland 21001 Paula Washenfeldt/daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of July^{Date}l, 2011 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot cemetery, crematory or other place)
Evans Funera
Chapel Bel Air 1 Durial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses PEACEFUL Afternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician disease or condition resulting in death) MINUTES Medical Du to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury as the bunal-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical requires that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Pregnant at time of death 1 Yes 2 9 Unknown the 9 Unknown P.O. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by be Records, 2 1 No 1 🗌 Yes 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an awı has page 2 s autopsy performe To the Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 \(\square\) Nursing Home After this 28c. Injury at work?
1 Yes 2 No 27. Man of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 \square Pending 1 Natural 24 hours after death. Funeral Director: A Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day Year)

ARS2.

Signature and title of certifie

30. Name and address of

person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sig

NO

29c License number

EXAS STATION COURT

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death earson Month Physician/ 201 1044 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEC 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign Funeral 1 - M 2 - F Director or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21044 6500 115% filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ŏ Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) tOCK RUOM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature Puneral Service Licens e 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events bunial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Pregnant at time of death 2 No the 9 Unknown 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has director, page 2: autopsy perform certificate Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Medical 2:15 PM 2011 A141+ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lectwood more If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Country) MD. (Month, Day, Year, 1 **№** M 2 🗆 F Months Days Min 214-56-43 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** Baltimore 1 Z Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2211 fleetwood Ave U.S.A 21214 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ISAble Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marian Sommerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia . Page 1 and 2 sh tment of Health a tant: If item 27 is 5426 masfiel Rd. 21229 reoples 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY 07-01-2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee TILTAM ACCORS BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ULMONAA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Opivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) address of person who completed cause of death (Item 23a) (Type, Print) 601 LOCH RAVEN BLVD. BALTIMORE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Year John Michael Pratt 12:05AM JUNG 24 /Medical 201 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs 5. Social Security Number 6. Sex **Funeral** . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birtippiace (State or Foreign Months Days Hours Min. Year) **1** M 2 □ F Director 178-60-1139 75 June 25. 1935 **England** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be motified at Director 1 TYes 2 N No. Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1434 Glenville Road 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🙀 No δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Nuclear Engineer Scientific Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyril (nmn) Pratt Gladys Ivy Rodwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health an Elizabeth M. Pratt / Wife 1434 Glenville Road, Havre de Grace, MD 21078 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages Depertment of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-27-11 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home,
1317 Cokesbury Rd., A Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ceremovahulh /Medical Due to (or as a consequence of) Examiner Phelippia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or, attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ancima Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Worken Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day □Yes 5 Other (specify) 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 💢 o 24a. Was an autopsy 2 [1 🗆 Yes 2 🕽 🌠 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Thomas C. Pulliam 27 :35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1 X M 2 □ F Months Hours **Director** 578-07-5323 101 1909 Virginia December 11 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 1927 Stanley Avenue 20851 United States death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ğ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 Yes If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Groundsman Country Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Jefferson Pulliam Lottie Edna Oakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Judith C. Naugle/Daughter 3421 Everette Drive, Bowie, Maryland 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9 cemetery, crematory or other place July 2, 2011 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service-ticensee
HOLON 1. HOL Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, Maryland M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ONAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any Leading to immedicause. Enter Underlying Due to or as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 4 Pregnant 9 Unknown ed by the a detached f s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE 1 Yes Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending within 24 hours at er death.

To the Funeral Director: A completed filled in by the fu Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0061096 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE ROND ROCK 31. Date filed (Month, Day, Year) . Registrar's Sig State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3, Time of Death June Physician/ Edward A. Rachuba \mathbf{p}_{M} 29 1210 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Fallston 1810 Arabian Way If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland Social Security Number SeX 12 M 2 □ F 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Months 07/12/1922 88 **Director** 215–18–5100 Usual Residence of Decedent show 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi jury or other traumatic event, the Medical Examilier must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Harford Fallston Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21047 1810 Arabian Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married چ Baltimore, Maryland 21215-0036 1 Yes 2 X No Year or Dates. WWII Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Pookbinder Manufacturing 10 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 0 Helen Sobus John Rachuba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Arabian Way Fallston, Maryland 21047 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Jeannette Rachuba - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State semetery, crematory or other pla Saint Stanislaus Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State 07/02/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign our of Funeral Sergic Licentee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Paltimore, Maryland 21231 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CANCEL SQUAMOUS CELL CA Physician/ LEFT EAU Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and I for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No 1 Yes 2 9 Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by IT BRILLMON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an cate has page 2 s autopsy performed? HYPEN NESION 1 Tyes 2 No ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Yes 2 ☐ ¥6 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 6/30/11 H 40769

Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) **JUL 0 1 2011**

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32. Registrar's 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE NANETTE 29, RAAB 2011 8:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ATRIUM VILLAGE ASSISTED LIVING BALTIMORE OWINGS MILLS 5. Social Security Number if Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Hours 099-18-9246 84 ON7267 1927 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No BALTIMORE MD **SPARKS** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15712 YEOHO ROAD 21152 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 XWidowed 4 Divorced Specify Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with... ∽tal Hygiene. `~r than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev HERMAN FRANK FLORENCE MARCUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY RAAB/DAUGHTER 15712 YEOHO ROAD, SPARKS, MD 21152 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. LEBANON CEMETERY: 06/30/2011 GLENDALE, NY of Fundral Servi / Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one vause an each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): the burial attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ģ Pregnant at time of death Unknown the 9 Unknown þ signed t significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an ate has page 2 s autopsy perform death? certificate 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 🗹 No Other: 1 L Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending injury 1 Yes 2 No Accident within 24 hours after death

To the Funeral Director:
coπpleted filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Ceryffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signature 29d. Date signed (Month. Dav. Year. 71208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 28/2011 Physician/ Jay B. Shank 12:55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Health Care Center Sykesville Carroll Social Security Number Birthplace (State or Foreign Country)
 PA If Under 1 Year If Under 24 Hrs Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 XM 2 □ F Months Hours 1757 1931 186-28-5713 80 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Sykesville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 7010 Carmae Rd. 21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married þ 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1953-55 1 ☐ Yes 2 X No Specify: Specify: 3XXWidowed 4 ☐ Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Silk Screen/Civil Servant Printing Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file the and Mental F. 7 is marked of မ Jacob B. Shank Esther Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ginger M. Shank/Daughter 27 W. Hickman St., Winchester, KY 40391 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 7/1/2011 Winfield, MD ature of Funeral Service Licenses ²²Burrierd Outer Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications that or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final in Death Physician/ evebrovAsc disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter or derlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed and tran Due to (or as a consequence of) resulting in death) Last buria physician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🖪 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending injury ours after death neral Director: A filled in by the fi 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier eted (Checke within 2

To the I Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d, Date signed Month, Day, Year

State Registrar alee

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

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2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201 1:45 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of De 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min. 1 🗆 M 2 🔀 F Hours Country) 95 **Director** 013-03-9799 7,1915 December Massachineetts Usual Residence iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2 Tr No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2321 Covered Bridge Garth 21234 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ▼ Widowed 4 □ Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamst<u>ress</u> Grue Tailoring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix Dobrowolski Anne Dougwillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type, Print) Frances Fuller (Daughter) 2321 Covered Bridge Garth Parkville, Maryland other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 05. injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 4 Donation 5 Other (Specify) 2011 Dundalk, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility any Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 mon Month Year Pregnant at time of death Day been signed by the should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed After this certificate 1 Yes 2 No 25. Was case referred to predical funeral director. Be 26. Place of Death (heck only one) examiner? Hospita Other: ျ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hame 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manney f Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Vatural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation after death the 3 Suicide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30/11 June 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshalee Dr. Elkiche 6095

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

ennina

32. Registrar's Signa

Year)

0 1 2011

James Roland Stallings

		1- For State Registrar		Cert	tificate of	Death		Reg. No.					
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd JAMES R.	STALL					2. Date of Dea Month June 26, 2	3. Time of Death 0307 hrs				
		4a. Facility Name (if not institution Johns Hopkins Bayvie			4	b. City, Town, or L Baltimore	ocation of Deat	n	4c. County of	of Death			
Funeral Director		5. Social Security Number 089-76-9566	6. Sex	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mir		•	9. Birthplace (State or Foreign Country) NY			
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											
faryland 28a-f sho	Director	MD HARFO 10e. Street and Number	ORD		J0	PPA 10f. Zip Code		1	0g. Citizen of Wh	1 Yes 2 No			
r death with the Maryland or items 23s or 28s-f sho must be potified at once.		722 FALCONER RI		cedent Ever in U.S	S. 13. Was	21085 Decedent of Hisp	anic Origin? (S	pecify Yes or No	U.S.A	- American Indian, Black,			
75 A L	by Funeral		orced If Yes, Give Yes or Dates:	2 X No		es, specify Cuban, Yes 2 X No		Rican, etc.)	White, etc. Specify: BLACK				
5-0036 led within 72 hours after Hygiene. other than "natural" the Medical Examine.	Completed b	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (during mo	's Usual Occupations of working life. I	DO NOT use re		16b. Kind of Bu				
21215-0036 And be filed within 7 Mental Hygiene. marked other than c event, the Medical		12 17. Father's Name (First, Middle,	Last)		FURK L	11	B.Mother's Nam		Maiden Surname)				
2121 Suld be fi Mental i marked	To Be	ERIC GEIGER SR 19a. Informant's Name/Relations			19b. Mailing			L. STAL: Rural Route Nur		n, State, Zip Code)			
e, MD I and 2 sho Health and item 27 is traumati		JANICE GIEGER/I	MOTHER	20b. Pl		ALCONER		PA, MD		City or Town, State			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 \(\bigcap \) Burial 2 \(\bigcap \) Cremation 4 \(\bigcap \) Donation 5 \(\bigcap \) Other S _A	pecify:	rom State cr	rematory or oth RGREEN	er place) CEMETERY	07	-02-201	BROOKL	YN, NY			
	1	21, Signature of June 15 tryice Licensee 22. Name and Address of Facility William C. Brown Comm. F/H-Harford P.A. 321 S. PHILADELPHIA BLVD. ABERDEEN, MI 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Madical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a, Multiple Inj			o mode of dying, o		or respirately air		Approximate Interval Between Onset and Death			
	٦	Sequentially list conditions, if any, leading to immediate	b	a consequence of)									
	Examiner	cause. Enter Underlying Cause (Disease or hijury that initiated events resulting in death) Last	С.	a consequence of)		***							
1760, ficate be executed g physician and the burial - transit		UNPENDED	d	4a,28c,pe	er me. o	917 7-14-	-11 sm	_					
8760, ificate be e		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of pregna	ancy				23d. Date of				
Box 687 ne death certific the attending I	Physician	past 12 months?	I TIVE I	oirth nant at time of dea own	th =	al death 3 _ er <i>(Specify)</i>	Ectopic pregn	ancy	Month	Day Year			
P.O. I es that the igned by the detached		Part II. Other significant condit	ions contributing to	o death but not res	sulting in the ur	nderlying cause giv	en in Part I.	-		bute to the cause of death? Probably 4 Unknown			
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed auth. or: After this cert ficate has b. on signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transition.	Completed by					<u></u>			osy p rm <u>ed</u> ? d	Vere autopsy findings available infor to completion of cause of leath?			
H. The		25. Was case referred to medica				26.Place o	of Death (Check	1 ✓ Yes only one)	2 100 1	Yes 2 No			
of Vital Ing Physician:	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗹 E	ER/Outpatient	3 DOA	ther Nursi	ng Home 5	Residence 6	Other:			
ion of Atenticate.	ation: T	27. Manner of Death 1 Natural 5 Penc 2 ✓ Accident Invest	28a. Date (Month Jun 26, stigation	Day Year)	28b. Time of In 0237 hrs		at Work?		how injury occurre struck by auto				
Division Bospital or Attendin 44 hours after death. Funeral Director: A	Certification:	3 Suicide 6 Couldeter 4 Homicide	d not be 28e. Plac	e of Injury - At hor Major Road		, factory, office bu	ilding, etc.	or Town, S	itate)	er or Rural Route Number, City r Road, White Marsh, MD			
hin the	Medical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	mysician: To the besing miner: On the basis and manner s	of examination and	e, death occurr d/or investigation	ed at the time, date on, in my opinion, e	e and place, and death occurred	due to the caus at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)			
To with	Me	29b. Signature and title of certified				29c. License O.C.M			29d. Date signe June 27, 20	ed (Month, Day, Year)			
4	ł	30. Name and address of person			-			D 21222					
St	ate		sistant Medical	egistrar's Signatur		nore Street, B	allinore, M	J 21223					
Regist		31. Date filed (Month, Day, Year)	Chara	N. Mari	arrive								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MUS home, 20 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗐 M 2 🗆 F (Month, Day, Year Months Days Hours Min Director Maryland 217-78-6498 Dec 18, 1958 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🕇 Yes 2 🗆 No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21230 2606 Rittenhouse Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes. Give Black Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Fencing Company** Fence Installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillie Simpson Edmondson Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2...
Department of Health a Important: If item 27 2606 Rittenhouse Avenue Baltimore, Maryland 21230 Nesmith Owen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buriai 2 Cremation 3 Reproval from State Windsor Mill, Md 06/29/11 4 Donation 5 Other (Specify) King Memorial Park neral Service Lic 22. Name and Address of Facility 21. Signatur Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21 23a. Part 1. Eyler the disease, or complications that shock, or heart failure. List only one cause on e e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mnediale Medical Due to (or as a consequence of **Examiner** TERM Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Y-PANI To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Coh Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No ed by the a detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the Funeral Director: After this certificate has been signed in pleted filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗌 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 Inpatient 22 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1/2 Natural 5 \square Pending work' 1 Yes 2 🗌 No Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 24

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

Soft Honover St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please State Registrar	State of M		d / Depa	rtme		Ith and N	/lental Hyg		Legible.	2	132	
Physiciar Medic		1. Decedent's Name (First, Middle, La	SADLE!	2					2. Date of Dea	ath	20 Year	3. Time of 7:48	Death A M	
Examine	er	4a. Facility Name (if not institution, given the second se	cal Cen					ure			n/a			
Funeral Director			1 DM 25 F	e (In yrs. I 76	ast birthday) Yrs.	Months		Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Day April 4		Cour	place (State c etry) rgia	r Foreign	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	rector	10a. State 10b. County Maryland n/a	1		y, Town or Loc altimor		ity			10d. Inside City Limits 1 ★ Yes 2 □ No				
	neral Di	10e. Street and Number 4 Elmwood Road				10f. Z	p Code 212	210		10g. Citiz	en of What Cou	ntry? SA	-	
	2	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		If	Yes, spe	edent of Hispani ecify Cuban, Me 2 🏿 No Sp	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
	omplet	15. Decedent's (Specify only highest (Elementary/Seconday (0-12)	grade completed) College (1-4 or 5	ō+)	(Give k life. DC	ind of we NOT us	ual Occupation ork done during se retired)		ing		d of Business In	dustry		
l be filed wit fental Hygie rked other tic event, th	To Be C	3 Volunteer & Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Ruth Kay												
nd 2 should saith and N n 27 is ma er traumai		19a. Informant's Name/Relationship John H. Sadler,		and)		-	ss (Street and N				own, State, Zip and 212			
. Page 1 al tment of H tant: If itel jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Place of Dispos cemetery, crem 1top Ser	vice	corp.	6/30	Date /2011		vson Ma	ryland		
permit Depart Impor any in		Michael &	ack by		Ruc	ck To		eral Hom	e, Inc. 1		ork Road	2 Towson,	1204 Md	
Physician/ Medical Examiner		23a. Part 1. Enter the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disases or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.												
e be executed ysician and e burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Medie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fet	al death 3 🗌	Ectopid	pregnancy specify)			2	23d. Date of delive	-	Year	
uires that th n signed by ald be deta	ed by Pl	Part II. Other significant conditions	contributing to death I	but not res	sulting in the u	nderlying	g cause given in	Part I.	23e. Did t		Se contribute to t	the cause of o		
The law requared cate has bee page 2 shou	Completed								24a. Was auto perfo 1 \(\sum \text{Yes}\)		death?	opsy findings ompletion of a		
ysician: is certifii director,	To Be	25. Was case referred to medical examiner? 1 Yes No	Hospital:	tient 2 🗆	ER/Outpatien	nt 3 🗆 I	Othor	of Death (Chec		dence 6	Other (Specif	y)		
To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no		ury ay, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes	2 🗆 No	28d. Describe I					
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu		4 Homicide determine	ed 28e. Place of Inj building, et	tc. (Specif	ý) 				City or Tov	vn, State)	Number or Rura		ber,	
he Hosp in 24 hor he Fune ipleted fi	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of clurse Practioner: To the	examinatio	on and/or invest	tigation, i	n my opinion, de	eath occurred a	at the time, date	and place,	and due to the ca	ause(s) and m	anner stated	
To the with To the com		29b. Signature and title of certifier	cocy -		ıdın	1		399		tru	e signed (Month,	1011		
/		30. Name and address of person wh	o completed cause of	death (Iter	m 23a) (Type, F	Print Pac	N 8T.	Bal	Pirune,	ll	0 212	20		
Stat Registra		31. Date filed (Month, Day, Year)		rar's Signa		Me	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3:27 P Werner Schock Physician/ JUMPeth 27ay 201^a1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Oak Crest Care Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jumyth, Par Year 931 . Social Security Number 216-36-2866 6. Sex 1 🗷 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 79 Germany **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8820 Walther Blvd 21234 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🏲 No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (154 or 5+) Woodcraftsman Marine Barracks Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhelm Schock Louisa Lumpe permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2614 Luiss Deane Dr. Parkville, Maryland 19a. Informant's Name/Relationship (Type, Print) Jeffrey Schock / Son 21234 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Parkwood Cemetery 6/30/2011 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral S 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ Medical Cerebrovascular disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buna Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? detached for Month 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Multi-infarct Dementia Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Hospital or Attending Physician; The 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 24 hours after death. Funeral Director: A ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one) 29b. Signaturq 29c. License number (pr who completed cause of death (Item 23a) (Type, Print) artison care man 8800 Walthor Blud, Parkville, MD 21234

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29b. Signature and title

STEVEN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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29d. Date signed (Month. Day, Year)

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		1	For State of Registrar	Marylan		artment tificate			nd Mental H	Hygien Reg. N		100	35
	H.		. Decedent's Name (First, Middle, Last)						2. Date of	Death		3. Time of D	
	Physicia Medic	al	James of James									10:40	РМ
	Examin	er	4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital Ab. City, Town, or Location of Death Rockville								c. County of Death Montgome		
1	Francis		· · · · · · · · · · · · · · · · · · ·	7. Age (In yrs. Ia	ast birthday)	If Under	1 Year	If Under 24	4 Hrs. 8 Date of	Birth	9 Birth	nplace (State or	Foreign
.	Funeral Director		042-28-3608 1 M M 2 🗆 F	75	Yrs.	Months	Days	Hours	Min. Septem	ber 18	,1935 Conr	iecticut	
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1	or 28	اقّ	10e. Street and Number			10f. Zip	Code				Citizen of What Cou		
7	n with	Funeral Director	9802 Dairyton Court				208				ited Stat		
}	death r item iner n		1. Marital Status 1 Never Married 2 Married 12. Was Decer	dent Ever in U.S	52 –	Vas Deced f Yes, spec	ent of His ify Cubar	spanic Origi n, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White		
036	s after ral", o Exam	d by	3 X Widowed 4 Divorced If Yes, Give Year or Da	109		I ☐ Yes 2	2X No	Specify:			Specify: Whi	te	
5-0	natur dical	plete	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usua kind of wor	il Occupa k done di	ation uring most o	of working	1	Kind of Business I		
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lan d	d be fi /lental arked itic ev	유	William Alexander Selbie	<u> </u>				Caro	line Jame	es			
Maryland	should and h is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address	(Street a	nd Number	or Rural Route Nu	mber, City	or Town, State, Zip	Code) 443	
	and 2 Health em 27 ther t		Diane C. Abbott /Daughte		Place of Dispo						Location - City or		
A M.C.	age 1 ent of nt: If it y or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State C	cemetery, crei tgomery (natory or o	ther place	Inc.	July I, 2011	1	thesda,		d
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ligensee	M01305						e/Rocl	kville, Inc e, Maryland	°20850–28	305
			23a. Part 1. Exter the disease, or complications that c shock, or heart failure. List only one cause on ea	aused the deat	th. Do not ent	er the mode	e of dying	g, such as c	ardiac or respirato	ry arrest,		Approximate Interval Betv	9
	Pnysician/		Immediate Cause (Final disease or condition	Iti ov	gan	dys	fur	ictio	n		10	Onset and D	eath
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687	certific iding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, out			7					23d. Date of de	livery	
Box 6876	requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	in the past 12 months?	Birth 2 Fet nant at time of lown		☐ Ectopic ☐ Other (sp					Month	Day Y	/ear
P.O.	that th	y Ph	Part II. Other significant conditions contributing to d	eath but not re	sulting in the	underlying	cause gi\	en in Part I.			o use contribute to		
	quires en sign	ted	bacterenia							1 🗌 Yes	2 No 3 P		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Completed by								Was an autopsy performed Yes 2	prior to death?	topsy findings a completion of c s 2 \(\sime\) No	available ause of
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٦	ne Hospita n 24 houra ie Funera bleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base only one) 3 Certifying Nurse Practioner:	est of my knov sis of examination To the best of m	wledge, death on and/or inve ny knowledge,	occured at stigation, in death occu	t the time my opinioured at the	e, date and p on, death oc ne time, date	place, and due to to courred at the time, of and place, and due	ne cause(s) date and pla to the cau) and manner as st ace, and due to the se(s) and manner as	ated. cause(s) and ma s stated.	inner stated
	To the I within 2 To the I comple	[29b. Signature and title of certifier	NO		290	c. Licens	e number	01	29d.	Date signed (Mont	h, Day, Year)	
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30×			30. Name and address of person who completed causes Sonie John, MD 996	se of death (Iter	m 23a) (Type,	Print)	er D	vive,	Rock	ille	ace, and due to the se(s) and manner as Date signed (Mont	and 20	850
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2011	registral s Sign	par	Kel							

Registrar DHMH 17 Rev 7/2009

JAMES SELBIE JUNE 27, 2011 2340 Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 29,2011 Physician/ Thomas Tress 11:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Gilchrist Hospice Towson Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days August 9 1943 Maryland Director 219-42-7139 67 Usual Residence of Deceden or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** notified 1 Yes 2 □ No Md. Baltimore 123a o, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Montpelier Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc þ "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clothing Company 12th Clothes Cutter and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Edward F. Tress Lillian E. Seeders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 <u>Shirley Tress</u> Spouse <u>618 Montpelier Street</u> Balto. other Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. XBurial 2 ☐ Cremation 3 ☐ Removal from State Paul Evangelical 7-2-2011 Perryman, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signar e of Funeral Service Lice see 9705 Belair Road Nottingham, Md. 21236 £ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ verla Medical resulting in death) Due to (or as a Examiner itustati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: use If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Cectopic pregnancy
5 Other (specify) in the past 12 months? for Month Year Day Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion autopsy performed' 1 🗌 Yes 2 No director, Be Was case referred to medica 26. Place of Death (Check only one) examiner? 2 HNo မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation after death Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Dii

completed filled in Medical etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 10070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Suite 4105 Balhman MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 29, 2011 Year Frances Mildred Torsella Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Sandtown N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ApriT 1 🗆 M 2 🗶 F Months Hours 217-20-0961 ^{Year)}1924 Vrs Pennsylvania Director 87 Usual Residence of Decedent 28a-f show 10a. State 10b County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified N/A Baltimore 1 X Yes 2 □ No MD ь 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 21217 1000 North Gilmore Street USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hyglene. ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3℃ Widowed 4 □ Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work dene during most of working life. DO NOT use retired) r than " Elementary/Seconday (0-12) College (1-4 or 5+) PHH Corp Data Entry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Crocamo Elvira Fusco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Torsella, Jr-son 14127 Blenheim Road-Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Woodlawn Cemetery July 2,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signatore of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate EMENTIA Immediate Cause (Final Onset and Death Physician/ disease or condition 🏃 Medical resulting in death) Due to (or as a consequence of): Examiner 5 NI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed?

1 Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) ATTENDING 10056948 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229

DHMH 17 Rev 7/2009

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Registrar

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2. Registrar's Signature

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TANSINDA

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ORMAN かい 1:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **Z** M 2 □ F Days Hours Mir December 29 Months 1930 Pennsylvania 210-20-0427 Director 80 Usual Residence of Decedent show 10b. County with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Maryland Anne Arundel Edgewater ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 204 Beverly Avenue 21037 United States items permit, Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner rmed Forces? Black, White, etc. o. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 - Widowed 4 - Divorced Specify: White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Van Norman Gladys McKillip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Joyce L. Van Norman/Wife 204 Beverly Avenue, Edgewater, Maryland 20137 other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gate of Heaven Cemetery July 2, 2011 Silver Spring, MD 21. Signature of Funeral Service Robbert A. Pumphrey Funeral Home, Rockville, Inc. 20850 M01530 300 W. Montgomery Ave., Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final HRONIC ONGESTIVE Physician/ 1 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Esquentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical · Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 4 ☐ Pregnant 9 ☐ Unknown isigned by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe after death.

Director; After this certificate! 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No ပ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 \quad Yes 28d, Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be

State Registrar

Medical

4 Homicide

29a. Certifier

(Check only one) determined

ne and address of person who dompleted

Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print

M M

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Frian Paul Wickes

0

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day June 26, 2011 Medical Examiner Brian P. Wickes 0230 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10510 Racetrack Road Worcester 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director Country New York 1 M 2 F Nov 3, 1949 095-42-9365 61 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester 1 Yes 2 X No Berlin Pages 1 and 2 should be filed within 72 bours after death with the Maryland nent of Health and Mental Hygiene.
amir If them 27 is marked other than "natural", or items 23a or 28a-f she or other transante event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f, Zip Code 10g Citizen of What Country? 10510 Racetrack Road <u> 21811</u> United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 X Yes 4 Divorced If Yes, Give Yeer or Dates: 1969. 3 Widowed 1 Yes 2 No specify: Specify: WHITE \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Corrections Officer Law Enforcement 12th grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Harriet R. Travers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman F. Wickes

19a. Informant's Name/Relationship (Type, Print) tment of Health and Mertant: If item 27 is may or other traumatic er Marcella Horbach 20a. Method of Disposition 6 Denver Drive, New York NY 10956 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory INC 4 Donation 5 Other Specify. 07-01-2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland 21. Signature of Funeral Service Licenses min 299 Frederick Road, Baltimore MD 21228 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Cardiac dilatation and hypertrophy complicated by Between Onset and /Medical Death a.smoke inhalation Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence or): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g917 7-18-11 sm X UNPENDED attending physician for use as the burial -To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth ted by the attending detached for use as 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 2 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown <u>P</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l ò 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. ficate has been si, page 2 should b 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No After this certific funeral director, p 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other | Nursing Home 5 Residence 6 🗹 Other Scene 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural subject inhaled products of Pending 1 Yes 2 X No completely filled in by the fd 6-26-11 fd 2:15 am 2 X Accident combustion Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10510 Racetrack Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) found in parked vehicle 4 Homicide Berlin.Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME June 27, 2011 MIL ture 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrar's Signatura

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Je	erome vvnite		State of Maryland / Department of Health and Mental Hygiene Certificate of Death	
	Physic ledical Exam		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
IV	iedicai Exam	ıner	Jerome White June 27, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	1441 hrs
			Sinai Hospital Baltimore N A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Annual Protein Court State of Security Number 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Yrs.	
	w any			10d. Inside City Limits
	Aaryland 28a-f show 1 at once,	ctor	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count.	1 Nes 2 No
	with the Maryland us 23a or 28a-f sho be notified at once,	al Director	709 Chestnut Hill 21218 USA	
	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Arman after death with the Maryland hand marked other than "natural", or items 23a or 28a-fah, T's in marked other than "natural", or items 23a or 28a-fah, mastie event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American, etc.) 17. Yes 2 No specify: 18. Race - American, etc.)	an Indian, Black,
	nours aft natural? Examine	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	dustry
	5-0036 ed within 72 l tygiene. other than "1,	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restruct	int
	215-0 be filed w mtal Hygic rked other	Be Co	17. Father's Name (First, Middle, Last) Charles J White Wae Orea	19
	imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. hant: If item 27 is marked other than or other traumatic event, the Medica	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 19b. Mailing Address (Street and Number or Rural Route Number, 2 19b. Mailing Address (Street and Number or Rural Route Number, 2 19b. Mailing Address (Street and Number or Rural Route Number, 2 19b. Mailing Address (Street and Number or Rural Route Number, 2 19b. Mailing Address (Street and Number, 2 19b. Mailing Address (Street and Number or Rural Route Number, 2 19b. Mailing Address (Street and Number or Rural Route Number, 2 19b. Mailing Address (Street and Number, 2 19b. Mailing Address (Street and Number, 2 19b. Mailing Address (Stre	Zip Code)) 21218
			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To	1
	Baltimore, permit. Pages l at Department of Het Important: If ite		4 Dogetiop 5 Other Specify: Mt. Carmel 7112011 Baltim 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howell Fuxula	O. Hoxus
	면 링스트로 Physician	\mathcal{A}	236. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	D 212/3 Approximate Interval
ŧ	Medical Examiner		failure. List only one cause on each Me. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between Onset and Death
		70	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	
		Examiner	cause. Enter Underlying Cause (Discuss or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
	50, te be executed sysician and burial - transit		d.	
	760, cate be ext physician he burial -	Medical	UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery	
	Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	i <u>a</u>	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	y Year
	P.O. B es that the de igned by the	by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	
	ords, P.C w requires that as been signed b	eted b		psy findings available
	of Vital Records, ng Physician: The law require that this certificate has been sinneral director, page 2 should b	Completed	autopsy prior to corperformed? death? 1 ✓ Yes 2 No 1 ✓ Yes	mpletion of cause of
	cian: certifi ector,	å	25. Was case referred to medical examiner? 1 Vives 2 No No No No No No No No	
	n of Vi ding Physi After this funeral dir	<u>ان</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject nedestrian struck by car	r in roadway
	SiOI Atten r death ector: by the	ertification:	1 Natural 5 Pending Investigation 2 Vacident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, etc. 28e. Place of Injury - At home, farm, street, factory, etc. 28e. Place	
	Divi	O	4 Homicide determined (Specify) Major Road / Highway 3100 Block of Reisterstown Road, Ba	
	Di To the Hospital within 24 hours a To the Funeral I	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
		Σ	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month) June 28, 2011	, Day, Year)
3	-	ł	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
		ate		*************************************
	Regis		31. Date filed (Month, Day, Year) OCME ORIGINAL	
	OCME 2006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2011 Year Esther Louise Walker 6:45 PM June 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1945 1 M 2 XF Month Hours 214-51-5031 66 Liberia Director June Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale 1 🗌 Yes 2 🕅 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Parham Circle Apt.1D 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: black 3√ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Calvary Baptist Elementary/Seconday (0-12) College (1-4 or 5+) Principal 12 Church traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ၉ William Bush Adelaine Watts 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2140 Amberly Glen Way-Dacula, Georgia 30019 Preston Padmore-son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) July 9,2011|Baltimore,Maryland Oaklawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and 8800 Harford Road-Parkville, Maryland Cremation Service 21234 torde condre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the sid be detached Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ESTHER WALKER by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has autopsy perform this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 \square Pending 1 X Natural thin 24 hours after death.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital or / Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year, Registrar

only one 29b. Signature and title

JACKIE JONES,

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			State of Ma	ryland / Dep					_	ne.	
		For State Registrar	- 10.10		rtificate of l		-	Reg. No	201	ç	2 1142
Physicia Medic		Decedent's Name (First, Middle, Las Charles	t)	Web	er		2. Date of Dea Month June 3		, 011 ^Y	'ear	3. Time of Death 2:30 A M
Examin		4a. Facility Name (if not institution, give 2213 Seneca Road	street and number)		4b. City, Town, o	r Location of Death		4c.	County of Balti		<u></u>
Funeral Director		5. Social Security Number 6. Se	PX 7. Age	(In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 20	th y, Year)	9). Birthpla	ace (State or Foreign
and show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation						d. Inside City Limits
e Maryl r 28a-f notified	Direct	Md. N/A			Baltimo	ore					1 XYes 2 No
s 23a o	Funeral Director	6405 Danville	· Ave.		10f. Zip Code	21224		109. Cit	izen of Wha	JSA	y?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates.	lo	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			America White, et Whit	c.
ithin 72 hour ene. • than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12) 7 years	ducation ide completed) College (1-4 or 5+	(Give	dent's Usual Occup kind of work done o O NOT use retired) Packe	during most of work	ing	16b. K	ind of Busir	ness Indu	•
d be filed w Mental Hygi arked other	To Be	17. Father's Name (First, Middle, Last) Joseph Webe	r			18. Mother's Nam	ne (First, Middle, Mary Bra		,		
nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship (Ty Regina Weber	wpe, Print) Wife	I		and Number or Run le Ave. I			-		ode)
. Page 1 a iment of H tant; If ite jury or otf		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, cren Oak Lawn	natory`or other plac				ocation - Cit ndalk,	•	rn, State Cyland
permit Depart Impor any in		21. Signature of Funeral Service Licens	mrelly	22	Name and Address Connelly	ss of Facility Funeral lers Poir	Home Of	Dur	idalk,	P.F	A. 21222
be eg	dical Examiner	23a. Part 1. Enter the distage, or compands, or heart failur. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Due to (or as a control of the co	consequence of):		y, such as cardiac		rest,		- 1	Approximate nterval Between Donset and Death Donset and Death
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	Ectopic pregnand	sy			23d. Date c Month		y Day Year
uires that the signed by all the deta	ed by Pl	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to				cause of death?
r: The law req icate has bee r, page 2 shou	Completed						1 🗆 Yes		prio dea	r to comp th?	y findings available pletion of cause of
ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 ER/Outpatien	Othe	ace of Death (Checker:		ence 6	▼ Other /	Specify)	Son's Home
nding Physician: The la ath. r: After this certificate ha ie funeral director, page	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	28b. Time of	28c. Injury work	y at	28d. Describe h			роспу	an s mie
ital or Atte urs after de ral Directo led in by th	al Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (28f. Location (S City or Tow	n, State)			
n 24 hou	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exame Practioner: To the be	mination and/or invest	igation, in my opinic	on, death occurred at	the time, date ar	nd place,	and due to	the cause	e(s) and manner stated
10.		29b. Signature and title of certifier			29c. License	number		29d. Dat	e signed (M	1onth, Da	ıy, Year)
10 m		30. Name and address of person who co			A+WOOC	1 st, 5	uite à	200	, Be	lair	21014
State Registra		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature							,

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 50 JOYCE PM ANN YOUNG ce Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Rosedale Baltimor Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Country)
CAROLINA Months Days Hours Min. 66 **Director** 248 80 9916 JÜNE 1945 N Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD BALTIMORE 28a-f ROSEDALE 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 4 PAVIA COURT USA Was Deceue... Armed Forces? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LUTHER WATTS DOLLIE ANN FOWLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY D. YOUNG / HUSBAND PAVIA COURT 1-C BALTIMORE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 07/01/11 BALTIMORE, MD Signature 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No Division of Vital Records, 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2/M No Manner of Death Hospital Other: 유 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier carlifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier opleted cause of death (Item 23a) (Type, Print) sew

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State Registrar iled (Month, Day, Year)

2000

Suno

32. Registrar's Signature

11-04813

Chong Wan Yim		State of Maryland / Department of Health and Mental I		2011 210L
Physicia		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Re-	g. No. 3. Time of Death
Medical Examir		Chong Wan Vim	Month June 28, 2	Day Year 011 1531 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Dea Baltimore	ath	4c. County of Death
Funeral		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		n(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		219-04-1609 1 1 2 F 55 Yrs. Months Days Hours M	Dec 1	3, 1955 Country) Korea
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
E	ភ្ន	MD Howard Ellicott Cit	4	1 Ves 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	10e. Street and Number	10	g. Citizen of What Country?
with th	<u>a</u>	3360 Sonia Vai 104 21043 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
r death	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No	to Rican, etc.)	White, etc.
2 hours afte "natural", Examine	ক্র	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind o	f work done	Specify: AS COVO 16b. Kind of Business/Industry
6 n 72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)		
15-0036 Iled within 72 hou Hygiene d other than "nat the Medical Exa	Completed	17. Father's Name (First, Middle, Last)	ne (First, Middle, M	Whole Sally aiden Surname)
be fill	Be	Pong Yim	K Yi	γ
MD 2. d 2 should lith and Mi n 27 is m.	잍	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 3300 Sonia Type)	Rural Route Numb	per, City or Town, State, Zip Code)
- a 3 5 5 1		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Het Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	2/2011	Hanover, MD
Baltimore permit. Pages 1 Department of 13 Important: If in injury or other		21. Signature of Funeral Service Licensee	towell	Funeral Home Jessup, MD 2094
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arres	
/Medical examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):		Death
		Sequentially list conditions, b		
	SL	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated		
ted d ansit	Exa	events resulting in death) Last Due to (or as a consequence of): d.		
oe executed cian and rial - transit	eg	UNPENDED AMENDED		
. 68760 certificate b nding physise as the bu	2 2	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant	annov.	23d. Date of delivery Month Day Year
Box 68760, re death certificate be extending physician the attending physician ted for use as the burial	Physician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	laticy	Month Day Year
C. Box: the death by the atte	֓֞֟֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓֓֓֟֡֓֓֓֓֓֡֡֡֡֡֓֡֓֡֡֡֡֡֓֓֡֡֡֡֡֡	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
s, P.O. B irres that the dansiand by the detached by the	9			2 No 3 Probably 4 V Unknown
ing Physician: The law requiring Physician: The law requiring After this certificate has been sfuneral director, page 2 should	Сощріетед		24a. Was an autopsy	
Rec The la ficate h			perform 1 ✓ Yes 2	
sician: sician: is certification	9 ·	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Nursi	, ,	esidence 6 Other:
ing Physical Grant Color of Vivieral directions of Vivieral directio		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	
Sion Vitendi death. ctor: /		1 Natural 5 Pending Jun 28, 2011 1500 hrs 1 Yes 2 No	Subject shot	
Divis	21	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street	or Town, Stat	eet and Number or Rural Route Number, City te) venue, Baltimore, MD
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.
To the He within 24 To the Fu completel		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number		d place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	٠,		CART	June 29, 2011
	3	30. Name and address of person who completed cause of death (Item 23a)		
	2 2	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B 31. Date filed (Month, Day, Year) 32. Replaces Signature	Baltimore, MD 2	21223
Stat Registra		JUI 0 1 2011 Green A Saules		
DHMH 17 Rev 1/200	1	ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Estelle Edwards Adams June 3:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Asbury-Solomons Health Care Center Solomons 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛂 Hours 0872771913 97 Director 125-32-5133 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c City Town or Location Director 1 ☐ Yes 2 🔀 No Maryland | Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 11750 Asbury Circle, Rm# 236 20688 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. ☐ Yes 2 K No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: White Completed 3 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Green John Dudley Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1464, Ignacio, CO 81137 Donald Adams / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 06/18/2011 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of ttending physician and for use as the burial-tran that initiated events resulting in death) Last to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the denth certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) signed by the of 4 Pregnant
9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe After this certificate has page 2 death?
1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director. completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Sectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Andrew A. Akinsola A^{M} June 1:10 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** nate of Day, 1 XM 2 | F Months Days Hours Min **1955** Nigeria 435-35-6772 Yrs. **Director** 56 Jan. Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f shormust be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Upper Marlboro 1 Yes 2 X No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6800 McCormick Rd. 20772 items 2 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Armed Forces? Black, White, etc ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Medicine Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Akinsola Alice Sowunmi traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Upper Marlboro, MD 20772 Clara E. Akinsola / Spouse 6800 McCormick Rd., 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Qther (Specify) Resurrection Cemetery 6/17/2011 Clinton, MD rice License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LEIOMYOSARCOMA disease or condition Medical resulting in death) ARCOMA OF RIGHT ELDOW. 104RS Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown 1 Yes 2 9 Unknown i signed by the aid be detached to detached Division of Vital Records, P.O. the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No No 1 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔊 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Accider
Suicide Investigation 24 hours after deat Funeral Director: in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ipleted filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only of 29b. Signa 29d. Date signed (Month, Day, Year) 0 0067588

Registrar

State

ployation drive #2005

Twho completed cause of death (Item 23a) (Type, Print)

JUN 1 5 2011

Registrar's Signature

	1 #20bper				se Type								_		_	ible.		
4ALU	HEALTON L	ępt '	. 6-10-11 K For 1 _ State	AH.	State	of M	larylan	•				and N	lental H	ygien	e 20		0 1	017
			Registrar 1. Decedent's Nam	ne (First Middle	Last)			Ce	rtifica	te of L	Jeath		2. Date of D	Reg. N	10. <u>L</u>		4	U4/
	Physicia		Erika A	,	, 2007								June 6	_	Ď11	Year	3. Time of 8:30	Death AM
	Medic Examin		4a. Facility Name (ii		give street and r	number)	_		4b. Cit	v. Town. o	Location	of Death	ourse (c. County	of Death	10.30	A'''
	,		2009 Sa:	int Geo	rges Way	7					Llvil						orge's	
1 6	Funeral Director		5. Social Security N 213-69-35	540	6. Sex 1 ☐ M 2 🛣	7. Aç	ge (In yrs. Ia 80	ast birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D DeC	irth (ay, Year)	930	9. Birthi Coun Swit	olace (State o try) zerlan	r Foreign d
	nd now	Ļ	Usual Residence of 10a. State	f Decedent 10b. County			10c Cit	v. Town or Lo	cation								0d. Inside Ci	A I imple
	arylar ia-f sl	Funeral Director	MD	Princ	e George	15		chelly								- [2X No
	or 28	Ö	10e. Street and Nur				1 0			ip Code				10g. C	itizen of V	Vhat Cour		
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ج</u>	11. Marital Status 1 Never Marr		12. Was D Armed 1 🔲 You If Yes,	Forces?	Ever in U.S KNo				ispanic Ori n, Mexical Specify		cify Yes or No Rican, etc.))-		k, White,		
8	atura cal E	etec	3 🛭 Widowed		Year or	Dates.		16a. Dece		111				1		Whi		
15	an "na Media	Completed		ecify only highe	st grade complet		5.)	(Give	kind of w	ual Occup ork done c se retired)	ation furing mos	t of worki	ng	16b.	Kind of Bu	ısiness Ind	dustry	
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Maryland 21215-0036	t be filed fental Hy rked oth tic event	To Be	17. Father's Name (Herman		ast)								(First, Middle Sagmeis		Surname	*)		
, Mary	nd 2 shouk salth and N n 27 is ma er trauma		19a. Informant's Na Valentir			augl	nter						Route Numb					 21
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth	0.0	20a. Method of Disp 1 XBurial 2 4 ☐ Donation	Cremation	3 ☐ Removal fro	om State	, C	lace of Dispo emetery, crer t Linc	natory or	other plac	e) :	UNK 16/1	8 / 1 1	1	Location -	•		
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1	Medical Examiner		resulting in death)	1	Due	to (or as	a consequ	ence of):										
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68760	rtifica ling pl e as t	/Me	IF FEMALE:															
. Box (I he law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medic	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, o	ve Birth egnant a	of pregnar 2 Fetal at time of d	death 3	Ectopic Other (S	pregnanc pecify)	у				23d. Date Mor	e of delive	,	'ear
P.O.	that ned b	by P	Part II. Other signif	icant conditio	ns contributing to	death b	out not resu	ulting in the u	inderlying	cause giv	en in Part	L	23e. Did	tobacco	use contri	bute to th	e cause of de	eath?
ds,	requires been sig should b	pel											1 🗆	Yes 2	! □ No	3 🗌 Prob	oabiy 4 X] (Jnknown
ecor	e faw re has be ge 2 sho	Completed											24a. Was		р		sy findings a	
<u> </u>	sıcıan: The la certificate ha irector, page 2	ပ္သို	25. Was case referre	ed to medical						00.51			1 Tes	2 X N		Yes	2 🗌 No	
/ita	lysician; is certific director,	To Be	examiner?		Hospital:	Innati	0 T I	ER/Outpatier	. . □ □	Lou	r: Deat							
of	g Phys er this neral di	ë	27. Manner of Death		28a. Da	inpati te of inju onth, Day		28b. Time of		28c. Injury	at		ne 5 Resi					
uo .	Attending Physician: If death. ector: After this certific by the funeral director,	licat	1 🔀 Natural 2 🗌 Accident	5 Pending Investig	ation	ontn, Daj	y, Year)	injury	М	work	? Yes 2 🗌	No		,				
Division of Vital Records,	i Dir afte	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could n	28e. Pla		ury - At hor c. (Specify)	me, farm, stre	eet, factor	y, office		2	28f. Location (City or To			r or Rural	Route Numb	эr,
:	ine Hospi nin 24 hou the Funer	Medical	(Check 2		Physician: To the caminer: On the b Nurse Practione	asis of e	xamination	and/or invest	igation, in	my opinio	 death oc 	curred at a	the time date.	and place	and due	to the cau	ise(s) and mar	ner stated.
			29b. Signature and t		Kou	at	cho	u, n	λ	c. License à 6-3	number 74	3		29d. Da	ate signed	(Month, E	Day, Year)	
	40		30. Name and addre															
	- A		Jocelyne 31. Date filed (Month	* Kouate					Mill	Rd,	Calve	ertor	, MD	2070)5			
	Stat Registra	_		JUN 08	2011	4	ar's Signatu	ire	0. 1	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard Raymond Adelman 2011 Medical June 10:15 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 902 Fortune Place Anne Arundel Edgewater Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** If Under 1 Year 8. Date of Birth 1 🔀 M 2 🗆 F Months Month, Pay, Year) 59 Washington, DC Director 215-74-9366 52 Yrs. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland <u> Anne Arundel</u> Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 Fortune Place 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1979 1 ☐ Yes 2 🏋 No Specify Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ٥ Raymond W. Adelman Barbara Marie Coffren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11100 Wildbranch Court, Owings Mills, MD 21117 Michael R. Adelman / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 06/15/2011 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Examin The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): ttending physician or use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the 1 Yes 2 9 Unknown 2 🗆 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? this certificate Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 X Yes 2 No Hospital Other: မ ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide Investigation 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Phys best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exan sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nur only one) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0056281 6/14/2011 30. Name and address of person who teolicause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Timothy P. Fry,

JUN 1 5 2011

31. Date filed (Month, Day, Year)

168 Braverton Street, Ste. 330, Edgewater, MD 21037

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mentb((TE 3 Medical 20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number g. Birthplace (State or Foreign Country) West Virginia **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 1 M 2 F Days 235-62-0328 Hours Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Marvland Anne Arundel Davidsonville 1 Tes 2 No 10e. Street and Number ö 10f. Zip Code ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral filed within 72 hours after death with 3516 Horseman Way 21035 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 1957—60 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married ģ Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify.White Completed 3 Widowed 4 Divorced If Yes, Give Year or Dates,1957–60 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene
Important: If item 27 is marked other the District Manager Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Clyde Franklin Angel Eleanor Virginia Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Angel / wife 3516 Horseman Way, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation Kalas Crematory 06/15/2011 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month 2 No Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s after death.

Director; After this certificate performe 1 Yes 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 400 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. License number 1000 Name and address of person who completed cause of death (tem 23a) Type, Print) DEFENSE HWY ANNA IGHT 14 100

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Valentine Marcelle Bowers June 15 09:30 A Medical 4a. Facility Name (if not Institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours May 30. 1928 Belgium **Director** 726 10 6675 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Temple Hills Maryland Prince George's Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a United States Funeral 20748 6708 Coolridge Road items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces
1 Yes 2 Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Cosmetic Rep/Ester Lauder 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmire Delfosse Etienne' Delborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Robey (Son) 6222 2nd St. Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State June 17, 2011 Clinton, MD 4 Donation 5 Other (Specify) Lee Crematory 21. Signatur of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Pregnant at time of death ed by the a detached f Unknown a Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Chiknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autonsy page perform certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes ER/Outpatient 3 DOA 욘 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? injury Natural 5 Pending thin 24 hours after death.

the Funeral Director: Aft
mpleted filled in by the fur 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical the basis of ex (Check on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse within 2 To the F actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b, Signature title c 29c. License number e of death (Item 231) (Type, Print State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Claire Denise Boswell Medical MAR 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In vrs. last birthday **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏋 F Hours 214-60-0046 Yrs. 11716/1956 Louisiana **Director** 54 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Calvert Prince Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 456 North Shore Drive 20678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Completed 3 Widowed 4 Divorced white Bosmell, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Desselle Tubre Norma Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie L. Boswell, husband 456 North Shore Drive, Prince Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Reproval from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 06/15/11 Alexandria, VA e of Funeral Service Lio 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Neumonia disease or condition Medical resulting in death) (or as a nsequence of) Examiner evosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dusito (or as a consequence of Examir the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months? Month Pregnant at time of death Day Year detached the Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? this certificate 2 No 1 🗌 Yes Yes 2 director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗗 No 1 1 မှ Inpatient 2 ... ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director A completed filled in by the fu hours a er death. Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Manne and address of person who c eted cause of death (Item 23a) (Type, Print) VIV-LRW

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland /		artment of H <i>tificate of D</i>		Mental H	_	2011	21052
			Decedent's Name (First, Middle, Last	t)		- 007	incate or E	Call	2. Date of D	Reg. N Death	10. 0	3. Time of Death
	Physicia Medic		William Ern	est Brown	1				June Month	8 [2011 Year	8:02 PM
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	Location of De	ath	4	c. County of Death	
-			Anne Arundel Med 5. Social Security Number 6. S				Annapo				Anne Arun	
	Funeral Director			MM 2 DE	lin yrs. last b 3	Yrs.	Months Days	If Under 24 H Hours Mi		iirth Day Ye <i>ar)</i> -192	9. Birthp Count Wash	place (State or Foreign try) D.C.
	7 A		Usual Residence of Decedent 10a. State 10b. County						103 +1	1,2		
	rryland	Director			I0c. City, To	wn or Loc					1	0d. Inside City Limits
	or 28¢	Dire	MD Anne Ar	undel <u> </u>			Deale 10f. Zip Code			10- 6	Citizen of What Coun	1 Yes 2 No
	with the	Funeral	456 Deale Road				20751			109. 0	USA	шуг
	death items	Fun	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.		Vas Decedent of His Yes, specify Cubar)-	14. Race - Americ	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No			☐ Yes 2 🏋 No		ito riicari, etc.,		Black, White, e	
0-0	hours natura lical E	Completed	15. Decedent's E	Year or Dates. 19		_	ent's Usual Occupa	ition		16h	Whit	
7	iin 72 ie. han "ı	dmo	(Specify only highest gra Elementary/Seconday (0-12)	de completed) College (1-4 or 5+)		(Give k	ind of work done do NOT use retired)	uring most of w	orking	.00	Till of Buoinoso inc	i don'y
2	d with fygien ther ti	Be C	47.5	4	I	oca1	29 Unior				ewspaper	
Maryland 21215-0036	be file ental H ked o c ever	To E	17. Father's Name (First, Middle, Last) Andrew Jackson	Brown,	Sr.			18. Mother's N Ethel	ame (First, Middle - Mae		,	
ary	nould Ind Ma s mar umati		19a. Informant's Name/Relationship (T)			9b. Mailin	a Address (Street a				rry or Town, State, Zip C	(ode)
Σ	nd 2 sl alth a n 27 is er tra		Patricia D. Brown	, Spouse			Deale Roa			2075		
Baltimore,	e 1 ar i of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Removal from State	20b. Place	of Dispos	sition (Name of atory or other place		Date	20c. l	Location - City or To	wn, State
Ħ,	it. Pag rtmeni rtant: rjury o		4 Donation 5 Other (Specif	v)	Metro						exandria,	
Bal	Depar Impo any it		21. Signature of Funeral Service Licens	Gio-	-		Name and Address	-			al Home, 1 s, MD 20	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	plications that caused the	ne death. Do							Approximate Interval Between
P	nysician/		Immediate Cause (Final disease or condition	Acute	My	CON	dial	Info	retion	1		Onset and Death
	Medical Examiner		resulting in death)	tye to (or as a c	onseque c	e of):	2					
	27	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence	e 01).			4			
7	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	· Mastro	inte	sti	ral 1	Blees	1			
	D 75 75 0	al E)	resulting in death) Last	Due to (or as a c	onsequence	e of):						
09/	physis the b	edical		d					<u> </u>			
20	inding use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of delive	rv
Rox	ueann he atte ed for	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at ti 9 Unknown			Other (specify)					Day Year
J. 5	at the d by ti letach	Phy	g ☐ Unknown Part II. Other significant conditions co		not resulting	n in the ur	derlying cause give	en in Part I	220 Did	tebases	use contribute to the	a source of death?
S, E	signe Id be o	d by	Non Hodkin.	1			, ,					ably 4 Unknown
ord	s beer	Completed	DOED Venou	s Thron	nbo	2:2			24a. Was			sy findings available
Vital Records,	ate ha	Com	- Deep -			- 1				opsy formed?	death?	npletion of cause of
נמן.	ertifica ector, I		25. Was case referred to medical examiner?					ce of Death (Ch		2 (342)	1 2 100	
T V	this c	. To	1 Yes 2 No 27. Manger of Death	lospital:				_ 4 □ Nursing	T		6 Other (Specify)	
0 1	th. : After	cate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Y		Time of injury	28c. Injury work? M 1 🗆 Y	at ′es 2 □ No	28d. Describe	how inju	ry occurred	
DIVISION OF	er dea ector	ertificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury		farm, stree					nd Number or Rural I	Route Number,
בו בו	ral Dir	O		building, etc. (\$	specity)				City or To	wn, State	e) 	
Hosp	within 54 hours after death. Within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 L Medical Examin	ician: To the best of my	nination and	or investig	gation, in my opinion	, death occurred	at the time, date	and place	e, and due to the caus	se(s) and manner stated.
To the	within To the		only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the bes		wieagė, de	29c. License		iace, and due to t			
			Styl	Ilp, m	4)		D58	5/0			ate signed (Month, D	//
SM	10+1	Ì	30. Name and address of person who c	ompleted cause of deat	h (Item 23a)	(Type, Pr	int)					
	Stat	е	31. Date filed (Month, Day, Year)	32. Registra's		11111						
	Registra	ır	JUN 1	3 2011 Den	wa	Ø.	Sparked					

11-04400 Michael Bullock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ichael Bullock		Sta	te of Maryland	/ Depa	rtment o	f Health	and	Menta	al Hygiene		20 i	1 21053
	E	- For State Registrar 1. Decedent's Name (First, Middle,	l aet)	Cer	tificate o	f Death			2. Date of D	Reg. No eath		3. Time of Death
Physicia Medical Examir	ier	Michael David	Bullock	_					Month June 11			1220 hrs
		4a. Facility Name (if not institution Anne Arundel Medical		r)	l	4b. City, To Annap		cation of	Death		Anne Arund	
Funeral	٦	5. Social Security Number 6			ast birthday)	If Under		If Under	_	,	I E O	Birthplace (State or
Director		579–98–4750	1XM 2 F	47	Yr	Months s.	Days	Hours	Min. Oct.	24,	1963	Country) Wash. DC
any	_ <u>_</u>	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion						10d. Inside City Limits
▶ . 11		Maryland Anne A	rundel				Anna	apoli	.S			1 Yes 2 No
hours after death with the Maryland 'natural', or items 23a or 28a-f show Examiner must be notified at once.	Director	10e. Street and Number 869 Cnestnut T	ree Drive			10f. Zip 0	ode 214	10g. C	g. Citizen of What Country? U.S.A.			
with the ms 23a be noti	la l	11. Marital Status	12. Was Deceder		S. 13. W	as Deceden Yes, specify	of Hispa Cuban, M	nic Origin	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ar White, etc	merican Indian, Black, c.
r death	Funeral	1 Never Married 2 Mail 3 Widowed 4 Divo		2 XX No		Yes 2					Specify:	Black
urs afte	<u>\$</u>	15. Decedent's Education (Speci	or Dates:	ompleted)	16a. Decede	nt's Usual O	ccupatio	n (Give kir	nd of work done	16b	. Kind of Busine	ess/Industry
2 -	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	r 5+)		nost of work ss Pro	ofess	siona	1		Fitn	ess
21215-0036 Juld be filed within 72 hours Mental Hygiene. marked other than "nature event, the Medical Exam	B	Nathaniel Bullock Barbara Sean wa.									.ace	
MD 21 id 2 should ilth and Mee in 27 is mai	٩	19a. Informant's Name/Relationsh Deborah Bullock			19b. Mailii 869 C	ng Address !hestni	(Street a LT Ti	and Numb	er or Rural Route N Drive Ani	lumber. napo	City or Town, S olis, Ma	tate, Zip Code) aryland 21409
	ŀ	20a. Method of Disposition			Place of Disponentary or o		of ceme	- 1	Date		c. Location - City	y or Town, State
Pages ent of unt: If		1 Burial 2 Cremation 4 Donation 5 Other Spe			ltimor	e Cre		_	6/20/201			e, Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	1	21. Signatur of uneral S, rvice L	icensee	7					John M.	_		
Physician	-	23a. Part I. Enter the disease, or o	complications that cause	ed the death.	. Do not enter	the mode of	dying, su	uch as car	rdiac or respiratory	arrest, s	shock, or heart	Approximate Interval Between Onset and
/ / / / / / / / / / / / / / / / / / /		failure. List only one cause of Immediate Cause (Final disease	on each line. a. Head Injuries									Death
: Xaiiiiii Ci		or condition resulting in death)	Due to (or as a con	sequence o	f):							
	횰	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	nsequence o	f):							
xecuted n and l - transit	Examiner	(Dispass or injury that initial ad events resulting in death) Last	Due to (or as a cond.	nsequence o	f):							
0 8.8	dica	UNPENDED	AMENDED									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buni	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	- Live birar	at time of de	2 🔲 l	Fetal death Other (Speci	3 [fy)	Ectopic	pregnancy		23d. Date of deli Month	ivery Day Year
O. B at the da d by the		Pert II. Other significant conditi			esulting in the	underlying	ause giv	en in Par				e to the cause of death?
S, P. uires th a signe Id be de	ed by								1 24a. W			Probably 4 Unknown e autopsy findings available
cords, law requii	Completed	-							au	itopsy erform <u>ed</u>	prior t? deat	r to completion of cause of th?
tal Rec		25. Was case referred to medical				2	6.Place o	of Death (0	1 ✓ Ye	es 2	No 1 ✓	Yes 2 No
Vita ysicia direct	To Be	examiner?	7.5	atient 2	ER/Outpatie	nt 3 D	DA C	other4	Nursing Home 5			Other:
n of Vi ding Physi 1. After this		27. Manner of Death 1 Natural 5 Pend	28a. Date of Ir (Month, Da) FOUND:	njury y,Year)	28b. Time of FOUND:	f Injury 2		at Work? es 2 ✔	Subject v		injury occurred in front of n	noving truck
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	2 Accident Inves 3 Suicide 6 Could	d not be Jun 11, 201 28e. Place of	f Injury - At h	_	reet, factory,			. 28f. Locatio	n State)	or Rural Route Number, City
lospital		4 Homicide	mined (Specify) Ir			curred at the	time, dat	e and plac				laire, Annapolis, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical	one) 2 Medicei Exam	miner: On the basis of ex and manner state	xamination a	and/or investig	gation, in my	opinion,	death occ	curred at the time, d	ate and	place, and due	to the cause(s)
F 3 F 3	ž	29b. Signature and title of certifie	11/			29c.	O.C.N				une 12, 201	(Month, Day, Year) 1
		30. Name and address of person	who completed cause of	of death (Iten	n 23a)							
- LH		Jack Titus MD. Dep	outy Chief Medical	Examine	er 900 W	. Baltimor	e Stree	et, Balti	more, MD 212	23	_	
S Regis	tate	31. Date filed (Month, Day Year)	5 2011 32. Reg 5	trar's Signat	ure A.	back	1					
Kegis	18:11	~ ~ ~ ~ ~	~~~			CONT.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month 2315 A M E11a Louise Bradshaw ure 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City. Town, or Location of Death ambridge Dorchester Dorchester General 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You June 14, 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** . 1924 Days Hours 1 □ M 2 🕱 F Maryland 218-16-5750 87 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Talbot Trappe 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3964 School Street 21673 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) certified nurses assistant nursing home land; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allan Messick Elizabeth Jones ျ Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Hickman daughter P. O. Box 193, Trappe, MD 21673 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 6/17/11 4 □ Donation 5 □ Other (Specify) Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service License 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician / /Medical Due to (or as a sonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumoni Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 5 Other (specify) the 9 Hloknown 9 Unknown signed by the following significant signif Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 **1**10 1 □Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this . Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours aft e Funeral Di letely filled ir 12—ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Day, Year) 30, Name and ordress of person who completed cause of death (Item 23a) (Type, Print) Porchester Ave 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	e of Marylan		artment of F tificate of L			001	1 ~ 1 ~
	· ·		Decedent's Name (First, Middle, Last)		001	inouto or E		2. Date of Death		3. Time of Death
	Physicia Medic		Mary E. William		:			June 13	Day 2011	9:30 P M
	Examir	er	4a. Facility Name (if not institution, give street and St. Thomas More	number)			Location of Death		4c. County of Dear	
7	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	lyattsvil If Under 24 Hrs.	8. Date of Birth	9 Bir	George's
	Director		577-34-2046 1 □ M 2 🗵	91	Yrs.	Months Days	Hours Min.	Dec. 2,	1919 Mas	^{untry)} sachusetts
	nd how at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	/laryla 8a-f s tified	recto	DC				Was	hington		1 X Yes 2 □ No
	a or 2 be no	E DE	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
	th with ms 23 must	Funeral Director	851 51st Street NE		1.00		20019			l States
(0	or itel	by Fu	Arme	Decedent Ever in U.S d Forces? Yes 2 🔀 No	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
21215-0036	ırs afte ural", I Exar	pe;	If Yes	Give or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify: B	lack
15-(72 hou "nata edica	Completed	15. Decedent's Education (Specify only highest grade comple	ited)	(Give I	lent's Usual Occupation of work done of	ation during most of work	ring 1	6b. Kind of Business	Industry
212	vithin liene. r thar the M	Con	Elementary/Seconday (0-12) Colleg	ge (1-4 or 5+)	lite. Do	NOT use retired) Housewi	fe		Priva	te
pu	filed v al Hyg d othe	Be c	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma	iden Surname)	
yla	uld be I Ment narke	잍		Williams				Emma Col		
Maryland	2 sholth and 27 is retraun		19a. Informant's Name/Relationship (Type, Print) Vera J. Butler - Daugh	nter					ity or Town, State, Zip	
	1 and of Hea item other		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of			0c. Location - City or	
Ë	Page nent c ant: If ury or		1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal t 4 ☐ Donation 5 ☐ Other (Specify)	rom State ce	metery, cren H ar m	natory or other plac ONV	June 2	011,		, Maryland
Baftimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once,		21. Signature of Funeral Service Licensee	wart, 2	0 22	. Name and Addres			neral Home ington, DC	, Inc.
			23a. Part 1. Enter the disease, or complications the	nat caused the death						Approximate
	Physician/		shock, or heart failure. List only one cause o Immediate Cause (Final disease or condition	n each line.	= ner	CARDIN	Mare at a		_	Interval Between Onset and Death
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		ē	if any, leading to immediate cause. Enter Underlying	to (or as a conseque	ence off:					
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	execular and Irial-tra	Ë	that initiated events c. ———————————————————————————————————	to (or as a conseque	ence of):					
760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d							
89	ath certifica attending p for use as t		IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnan	су				23d. Date of del	livon
Box	death e atter	Physician/M	in the past 12 months?	.ive Birth 2 ☐ Fetal Pregnant at time of de Jnknown		Ectopic pregnance Other (specify)	у		Month	Day Year
P.O. I	at the de	Phys	g Unknown 9 Unknown		Iting in the cu	adorbina esues aiu	an in Doubl	1		
	res that signed t	Completed by	Dementia An-Kul A						cco use contribute to	robably 4 Wunknown
ord	require been si should b	lete	Diables Welly to				20100100	24a. Was an		topsy findings available
Division of Vital Records,	The law cate has page 2	mo;	Chroma Kidary	Diseas	P.			autopsy performe	prior to death?	completion of cause of
Ē	sician: The certificate l irector, page	Bec	25. Was case referred to medical examiner?				ace of Death (Chec		A NO I des	ZLINO
f Vi	Physion this on	욘		☐ Inpatient 2 ☐ E	R/Outpatien		4 LMNursing Ho		ce 6 Other (Spec	ify)
o u	nding tth. : After e funel	cate		Month, Day, Year)	injury	28c. Injury work? M 1 🔲		28d. Describe how	injury occurred	
/isio	r Atter ter des rector by the	Certificate:	3 Suicide 6 Could not be	ace of Injury - At hon uilding, etc. (Specify)	ne, farm, stre	et, factory, office			et and Number or Rui	ral Route Number,
Ö	oital or urs aft eral Di		<u> </u>				9.	City or Town,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the Certifying Nurse Praction	basis of examination	and/or investi	gation, in my opinio	n, death occurred at	the time, date and	place, and due to the o	cause(s) and manner stated.
	Northi Comp		29b. Signature and title of certifier	0		29c. License	number	290	d. Date signed (Month	
		İ	Mondlin	Word	(tes)	100	1852	- ~	TUNE 10	12011
R	5		30. Name and address of person who completed of	cause of death (Item 2	23a) (Type, Pi	int)	uny Re	1 1/2,0	rttsolle	MD 2028
	Stat Registra	٠ .		2. Registrar's Signat	re			· · · · · · · · · · · · · · · · · · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0133 M Crouse Mae)une Medical Linda 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington Meritus Medical Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 20, 1944 Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 F Days Hours Director 214-46-5593 Maryland 67 May Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d, Inside City Limits MD Washington 1 X Yes 2 □ No Hagerstown ò 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 364 S. Locust St. 21740 U.S.A. within 72 hours after death or items 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Ş 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Packer Music and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lloyd Burgan Maurgarite Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Interval Rd., Hagerstown, MD Jean Whittington/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park |6/25/2011 Hagerstown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one ca Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 2 NO Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne Leath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No M Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital on within 24 hours aft To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death of d at the time, date and plants and due to the name (s) and manner as state 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person who col

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gynith M. Clark June Month Day 011 13, 5:08 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 4500 Pine Valley Court Middletown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Months March Dz 3 car) 1939 West Virginia 72 Director 234-58-8253 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Middletown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 United States 4500 Pine Valley Court items ? 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ò 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Divorced 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Education School Teacher +4 Be 18. Mother's Name (First, Middle, Maiden Surname) Jencie Tooley 17. Father's Name (First, Middle, Last) marked ည Denny Pridemore Department of Health and Ment Important: If item 27 is me-any injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4500 Pine Valley Court, Middletown, MD 21769 Paul Clark / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Olivet Cemetery | 6/17/2011 Frederick, Maryland Mt. eral Service 22. Name and Address of Facility Stauffer Funeral Home 21. Signatur 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ oronar disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician if or use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XNo

9 Unknown Year Day Pregnant at time of death ed by the detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after decade Director: After the fire Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined filled in I City or Town, State, 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier eted (Check within 24

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month. Day, Year)

State Registrar ames

31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important: If tiem 77 is marked other thao "oatural", or items 23a or 28a-f sho injury or other traumatic eveot, the Medical Examiner must be notified at occe.	은	Brian Paul Consi		1.0		Penn Nat				-		
e, K I and 7 Health item 1		20a. Method of Disposition		20b. Plac	ce of Disposi	tion (Name of cem		Date			or Town, State	
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Baltimore, permit. Pages lar Department of Hee Importact: If ite	1	21. Signature of Funeral Service Lic		, 001		ame and Address		0/10/2011	, 1	JULI SVIII	C PD	
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X 6 th cert the cert trendir r use a	icia	past 12 months?	4 Pregnant at	time of death	- =	er (Specify)		ognanoy		Worker	buy 100	"
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of Vital Records, P.O. Box 68760, iog Physician: The law requires that the death certificate be execute. After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the bunal - tran	ত্র	Part II. Other significant condition	s contributing to deat	n but not resul	Iting in the ur	nderlying cause giv	ven in Part I			✓ No 3 F	to the cause of deat Probably 4 Unkr	
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To the Ho within 24 To the Fu completel	edical	(Check only Certifying Phys	ician: To the best of m ier:On the basis of exa	y knowledge, o mination and/o	death occurr or investigati	ed at the time, date on, in my opinion,	e and place death occur	, and due to the c red at the time, d	ause(s) a ate and p	ind manner as s lace, and due to	stated. o the cause(s)	
5 ½ ½ 5 g	ŏ.	- 1	and manner stated.									

DOME

State 31. Date filed (Month, Day, Year)
Registrar

29b. Signature and title of certifi

Mary G. Ripple MD.

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

June 11, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year Rose Chiki 2011 : 2.0 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove Hospice House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Country) 204-36-2854 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland at Funeral Director 3a or 28a-f st t be notified a MD Frederick Middletown 1 Yes 2 No 10e. Street and Number 7394 Freestate Dr. 10f. Zip Code 10g. Citizen of What Country? 21769 USA 23a rral", or items 23a Examiner must b 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: than "natural", 3 N Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event injury or other homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pal Aszalos Jusztina Toth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Smith (Daughter) 7394 Freestate Dr., Middletown, MD 21769 20a. Method of Disposition

1 X Burial 2 Cremation 20b. Place of Disposition (Name of Center acidemathrous propertian 20c. Location - City or Town, State 3
Removal from State 4 Donation 5 Other (Specify) 6/17/2011 McMurray, PA Church Cemetery 1 Furier 1 Sept ce Litter Sign Cure ²Donal Addres of Farihompson Funeral Home POB 18, Middletown, MD se, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate r heart failure nterval Between Onset and Death Immediate Cause (Final Physician esavator disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury) Examiner Due to (or as a consequence of): and -transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician tached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months Day Pregnant at time of death g 🗌 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has when this certificate corage 2 No 1 Yes 25. Was case refe d to cal funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manne Death 28a. Date of injury 28b. Time of hours after death.

neral Director: After the filled in by the funeral 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu d title of certifie

State Registrar 30. Name and a

31. Date filed (Month

2916 00

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npleted cause of death (Item 23a) (Type, Print)

egistrar's Signatur

MELLAL.

4 2011

6/13/

Hagustown MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2011 Diane Lund Charowhas June 8:38 A.M 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Renaissance Gardens Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) May 9, 1940 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) Utah 1 □ M 2 🖾 F Months Days Hours Min. 556-50-7802 71 May Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No <u>Maryl</u>and Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3128 Gracefield Road 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black. White, etc. 1 Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Information Systems Director Laboratory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

10224 Day Avenue, Kensington,

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Mem. Park

Etta

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6/9/2011

Date

Maureen

Maryland 20895

20c. Location - City or Town, State

Rockville, Maryland

Thompson

Thorvald Lund

Russell

1 🔀 Burial 2 □ Cremation 3 □ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anna Korzan, M.D.,

31. Date filed (Month, Day, Year)

19a. Informant's Name/Relationship (Type, Print)

Chad E. Charowhas/Son

4 ☐ Donation 5 ☐ Other (Specify)

20a Method of Disposition

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. Baltimore, Maryland 21215-0036 Physician/ Medical For State Registrar

10a. State

Director

Funeral

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Completed

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Physician/

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Examiner

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Director

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Examiner page 2 s

and -tran attending physician a for use as the burialbeen signed by the should be detached has beer certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

-	21 Specture of Funeral Service License	*ORlalela		and Address of Facilit				MD. 20877
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	a. Acute T Cell Lyr Due to (or as a consequence of)	nphob1			espiratory arrest,		Approximate Interval Between Onset and Death 3 weeks
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ficate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury 28b. Tin (Month, Day, Year) inju		28c. Injury at work? 1 ☐ Yes 2 ☐		I. Describe how inj	ury occurred	
Medical Certificate: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	ı, street, fact	ory, office	28f	. Location (Street a City or Town, Sta		ral Route Number,
Medica	(Check 2 ☐ Medical Examin only one) 3 ☐ Certifying Nurse	ician: To the best of my knowledge, de ler: On the basis of examination and/or in Practioner: To the best of my knowled	nvestigation,	in my opinion, death oc	curred at the	time, date and pla	ce, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier		2	gc. License number		29d. [Date signed (Montl	h, Day, Year)
	I Ame Ko	and, Mo		D577	284	JU	N7	2011

3110 Gracefield Road, Silver Spring, Maryland 20904

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 25 per med cert G917 ///II dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $10^{^{\text{Day}}}$ June Physician/ 11:40 Am 20^{Year} June Carroll Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Heritage Harbour Health & Rehab. Ctr. Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🗓 F Hours 06/11/1926 579-26-5972 Washington, D.C. Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Anne Arundel Riva Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 21140 3073 Riverview Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 x Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Geico Insurance Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charlotte Minder Howard Devers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9623 Monroe Manor Road, Stevensville, MD 21666 Everett N. Thombs, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a Method of Disposition 20c. Location - City or Town, State Date 1 🔲 Burial 2 🏋 Cremation 3 🗆 Removal from State 06/11/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George F. Kalas Furieral Hollic 21. Signatur of Fall Service Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran: that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 11/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra, 600 Ridgely Avenue, #231 , Annapolis, Maryland 21401 gistrar's Signature State JUN 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:01 AM COUSINS June LEMUEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Laurel Regional Prince George's Hospital dure 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 □ **Funeral** Days Months Hours JUNE 20 1929 WASHINGTON, DC Director 579-34-0769 81 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 TyYes 2 No PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20708 12237 SHADETREE LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No ARMY If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc þ 1 Never Married 2 X Married BLACK 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT TEACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ WOODWARD HELENA JAMES R. COUSINS JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12237 SHADETREE LANE LAUREL, MARYLAND 20708 19a, Informant's Name/Relationship (Type, Print) STANLEY COUSINS/SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 6/27/2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Juneral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the g shock, or leart fai Immediate Gause (For disease or condition Approximate Interval Between Onset and Death Infarction Physician/ Myocardial Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Month g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Alzheimers Dementia 24a. Was an autopsy performed Yes 2 Disease ParKinson's 2 XNo 1 Yes 25. Was case referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D22966

Registrar DHMH 17 Rev 7/2009

State

Thomas.

31. Date filed (Month, Day, Year)

11 N 2. 0 2011

Thomas H. Burguieres,

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of perth (Item 23a) (Type, Print) Laurel Regional Hospital,

/Emergency

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Conteh 2011 Marian Thompson June 15, 3:15 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park B. Date of Birth
(Month, Day, Year)
June 16,1950

9. Birthplace (State or Foreign Country)
Sierra Leone; 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth . Social Security Number Funeral 1 🗆 M 2 🗶 I Days Hours 579-88-2000 60 Director Usual Besidence of Decedent show 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 No Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 7401 New Hampshire Avenue; Apt. 510 Sierra Leone,West Africa Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give 3 Widowed 4 Noivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Althea Woodland al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Housekeeper 12th grade event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Connie Thompson David Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Maryland f Health a item 27 i 7401 New Hampshire Avenue; Apt. 510; Takoma Park; 20912 Department of Health Important: If item 27 any injury or other tr Ahmed Bashiru Conteh (Grandson) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 2,2011 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Adelphi, Maryland George Washington Cemetery Mame and Address of Facility R. N. Horton Company Morticians, 21. Signatur of Funeral Servi-Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 our or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Onset and Death VOUCEN Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events eint Priserie sician and burial-transit Exami ナセいらい resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) 3 in the past 12 months? Pregnant at time of death 2 No ate has been signed by the a page 2 should be detached 9 X Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be xaminer? Other: 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To 28b. Time of 28a. Date of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2326 1201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr.; M.D.; 7600 Carroll Avenue; Takoma Park, Maryland 20912 James K. Lightfoot,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

11-0441	0
Charles	Colbert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examine. TO Be Commission by I		20a. Method of Disposition 1 X Burial 2 Cremation		Place of Dispos crematory or oth		or cem				l		-	
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		30. Name and address of person w	no completed cause of leath (Ite	m 23a)									
1		Theodore M. King, Jr., M.				Baltim	ore Stre	eet, Ba	altimore, MI	21 ט	223		
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture									

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1		•	Calvert Memorial	Hospital				Frederio			Calv		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birt)	hday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.				9. Birth Cour	nplace (State or Foreign ntry) New York
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	व	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ፟፟፟፟፟፟፟፟፟ Yes 2 □ No If Yes, Give Year or Dates1946-48				Specify:	to Ricari, etc.)		Black Specify:	White,	
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ည်	and Heal tem		20a. Method of Disposition	20b. Place o	f Dispos	sition (Nan	ne of	1	Date				Town, State
υOL	age 1 ent of nt; If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Herrioval Horri Otato		atory or o			/24/2011	Che	elte:	nham	n, MD
Baltimore,	permit. F Departm Importa any Inju		21. Signature of Funeral Service License		22.	Name an	d Addres	s of Facility R	ausch Fu	inera.	l Ho	me,	P.A.
m	an In Se		michael Kevry	Hardener J.							Lus	by,	MD 20657
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the death. Do re cause on each line.	not enter	r the mod	e of dyin	g, such as cardia	c or respiratory a	ırrest,			Approximate Interval Between
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9 X	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat	h 3 🗀	Ectopic Other (st	pregnano	су			23d. Dat Mo		ivery Day Year
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P.O.	requires that the death certificate be been signed by the attending physicis should be detached for use as the bu	Completed by Physician/Medical	Part II. Other significant conditions co	ntributing to death but not resulting	in the u	nderlying	cause gi	ven in Part I.	23e. Did	tobacco u	ise contr	ibute to	the cause of death?
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ior	Attending Physician; The sr death. ector: After this certificate by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		arm. stre	M eet factor		res 2 🗆 No	28f. Location	(Street and	d Numb	er or Ru	ral Route Number,
Division of Vital Records,	after Direc		4 Homicide determined	building, etc. (Specify)	arri, ou	201, 140101	<i>y</i> , σσ			own, State,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	death	occured a	t the time	e, date and place	, and due to the	cause(s) ar	nd mann	er as sta	ated.
	he Hc iin 24 he Fu ipleter	Med	(Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of examination and/ the Practioner: To the best of my known	or invest vledge, d	death occu	urred at th	ne time, date and	place, and due to	the cause(s	s) and ma	anner as	stated.
	To the company		29b. Signature and title of certifier	1.1		29	_	e number		29d. Da	te signe	d (Monti	h, Day, Year)
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74	1) 01.1		30. Name and address of person who o				rinc	e Freder	rick MD	2067	'8		
CN	Sta	ate.	Harshinder Sidhu, 31. Date filed (Month, Day, Year)	MD 100 Hospital 32. Registrar's Signature					LCK, IID		<u> </u>		
	Sta Regist			0 2011 Denus	1.	Soa	ile	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1. Decedent's Name (First, Middle, Last) 2. Date of Death March 3. Social Security Number 4. Social Security Number 5. Social Security Number 6. Sex 218-24-1339 1. March 10 Decedent 10 Deceden	Day Year 11.30 M 4c. County of Death Washington 9. Birthplace (State or Foreign County) Maryland 10d. Inside City Limits 1 Yes 2 \(\) No
Medical Examiner Medical Examiner Medical Examiner Medical Center Hagerstown Hunder 24 Hrs. Medical Center Hagerstown Hunder 24 Hrs. Medical Examiner Medi	4c. County of Death Washington 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 \(\) No
## As Facility Name (if not institution, give street and number) ## As Facility Name (if not institution, give street and number) ## Meritus Medical Center ## Meritus Medical Cente	Washington 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 ✓ Yes 2 □ No
Director Social Security Number 1.8	9. Birthplace (State or Foreign Country) Mary Land 10d. Inside City Limits 1 ✓ Yes 2 □ No
Director Direct	Country Mary Land
10a. State 10b. County 10c. City, Town or Location Maugansville 10b. City Town or Location 10b. City Town or Loc	1 ¥ Yes 2 □ No
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence) Sequentially list conditions, if any, eaching to minority cause. Enter Underlying	
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):	
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IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	COL Data of delivers
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He law requires the law to be a Seles Recipheral legellar to year autops perform to law to be a selection of the law to be a selecti	y prior to completion of cause of
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The second secon	once 6 Other (Specify)
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To read the property of the part of the property of the part of th	reet and Number or Rural Route Number, n, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and	d place, and due to the cause(s) and manner stated.
only one) 3 — Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and place, and due to the set of my knowledge, death occurred at the time, date and due to the set of my knowledge, death occurred at the time, date and due to the set of my knowledge, death occurred at the time, date and due to the set of my knowledge, death occurred at the time, date and due to the set of my knowledge, death occurred at the set of my knowledge, death occurre	gd. Date signed (Month, Day, Year)
D62588	06-20-2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State Registrar 31. Date filed (Month, Car Year) 2011 32. Registrar's Signature Leven S. Janes	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Henry Dekker June 13, 7:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9914 Greenbriar Lane Frederick Walkersville 6. Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year)1920 Days July 29 Virginia **Director** 043-12-7039 90 Yrs. Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 1 Tes 2 X No Maryland Frederick <u>Walkersville</u> ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 9914 Greenbriar Lane 21793 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", 3 Nidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) President Textile/Fashion injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည John Peter Dekker Frieda Tiedemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Alice Dekker/ Daughter 9914 Greenbriar Lane, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 No Cremation 3 Removal from State Stauffer Crematory Inc.6/15/2011 4 Donation 5 Other (Specify) Frederick, Maryland. 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, Signature of Juneral Service Prederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ to tenosclerot disease or condition Soft a Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death. I Director: Aft 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 00030020 06/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) challersulle, md 21793 Simtla M.D PO Box 310 31. Date filed (Month. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MPRH 10 201 gar Steven Mordecai Engel 12:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Middletown 301 W. Green St. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 10/1 Day Israel 1 □**X**M 2 □ F 212-64-3656 57 T953 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Frederick Middletown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21769 USA 301 W. Green St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2XXMarried þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify.White If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) construction courier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judith Grunwald Joel Engel . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801~W . Green St., Middletown, MD 2176919a. Informant's Name/Relationship (Type, Print) Linda Kinna-Engel (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2 ☐ Cremation 3 ☐ Removal from State tion 5 ☐ Other (Specify) cemetery, crematory or other place) Lutheran cemetery 6/13/2011 Middletown, MD Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Sign plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pne cause on each line. Approximate Interval Between on et and Death 23a Part 1. Enter the disease, or con Stock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner bue to for each non-section result. ri arry, leading to minediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown this certificate has been signed by the ral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 100 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ᅆ Certificate: 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1XX Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Sulciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Daye signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

4

32. Re

strar's Signature

31. Date filed (Month, Day, Year)

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar										
	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death							Year,	3. Time of Death	
-	Medic	Wedical								Year of Death	5:25 PM	
_	/	Seasons Hospice				Randallstown			Baltimore			
	Funeral Director		105-62-8034	7. Age (In yrs. last bir 46	thday) Yrs.	If Under 1 Year Months Days			3irth 9. Bi		place (State or Foreign "Tork	
	and show at	eral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Loc	ation				T	10d. Inside City Limits	
	Maryla 28a-f s otified		Maryland Anne Arun	del Sever	n				_		1 ☐ Yes 2 🛣 No	
	ith the 23a or st be n		10e. Street and Number 1804 Sparrow Court			10f. Zip Code 21144			10g. Citizen of US		ntry?	
	items	Funeral		Was Decedent Ever in U.S.	13. W	las Decedent of His	spanic Origin? (Spe	cify Yes or No- Rican, etc.)		ce - Americ	can Indian,	
9036	s after or ral", or Examin	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.			Specify: Puer				panic	
15-0	72 hou "natu ledical	Completed	15. Decedent's Educa (Specify only highest grade o		(Give ki	ent's Usual Occupa ind of work done d	ation uring most of worki	ng	16b. Kind of E	Business In	dustry	
212	within giene. er thar , the M	To Be Con	Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired) nasing Ag	ent		Hote:	ls		
and	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		17. Father's Name (First, Middle, Last) Jaime Brillon				18. Mother's Name Martha	(First, Middle, Aceved		ie)		
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (Type, Alfredo Escudero Me:		b. Mailing .804	g Address (Street a Sparrow	nd Number or Rura Court, Se	Route Numbe	r, City or Town, AD 2114	State, Zip	Code)	
ore,	e 1 and of Hea If item ir other	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rer	20b. Place o	ery, crem	sition (Name of atory or other place	e)	Date	20c. Location	-		
<u>H</u>	iit. Pagartment ortant: njury o	- 2	4 🗍 Donation 5 🗌 Other (Specify)	Mary1	Land	Nat'l Me	m. 6/20, ss of Facility Geo		Laurel	•	-	
Ba	Depar Impor any in);	21. Signatural Funeral Service Licensee	M. M			Hill Rd.					
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final	tions that caused the death. Do lause of each line.		or and the sour		r respiratory an	rest,		Approximate Interval Between Onset and Death	
in the second	Physician/ Medical Examiner		disease or condition resulting in death)	a. MV/1//2 MV 2/0MV Due to (or as a correquence of):						-		
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ds, P	requires that the de been signed by the should be detached	ed by						1 🗆	_/		obably 4 🗆 Unknown	
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r Vit	Physici this cer al direc	은	examiner? 1 Yes 2 No Hos	1 ☐ Inpatient 2 ☐ ER/O			4 U Nursing Ho		dence 6 🗷 Oti		JEAT HOSPICE	
o uo	I or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	Certificate:	1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		Time of injury	28c. Injury work M 1 🗀	y at ? Yes 2 □ No	28d. Describe h	low injury occur	red		
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The 24 hours after death. The The Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or At within 24 hours after o To the Funeral Direct completed filled in by	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/ ractioner: To the best of my know	or investi	gation, in my opinic	n, death occurred at	the time, date a	ınd place, and dı	ue to the ca	ause(s) and manner stated.	
	To the within 2 To the comple	-	only one) 3 L Certifying Nurse P 29b. Signature and title of certifier 30. Name and address of person who comp 1. S. Rajarakse 31. Date filed (Month, Day, Year) JUN 2 0 2011	ND:		29c. License	5 7 46 5		29d. Date signe	ed (Month,	Day, Year)	
2	5		30. Name and address of person who comp	pleted cause of death (Item 23a)	(Type, P	rint)	200 00	1d h = 1	-//0/	2 /1	09	
4-	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar Signat re	111-	H RU. S.	243 801	11791	C 1719	212		
	Registra		JUN 2 0 2011 🔑	way p. 19th								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12^{Day} Physician/ 201 Year Syble Mae Gieswein June 6:26 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 9213 Three Oaks Drive Silver Sprind 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Davs Hours 09/01/1925 Georgia 247-30-8582 85 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "notion." 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9213 Three Oaks Drive 20901 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 X No Yes, Give 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Cosmetic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Addison Stokes Nixon Amie Elza Rumsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Frederick Gieswein / Husband 9213 Three Oaks Drive, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State crlington National Cemetery 07/27/11 Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, PA. 21. Signature of Funeral Service Licenses Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 XXNo ed by the a detached 1 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed I e 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? certificate ha death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other 1 🗌 Yes 2XXNo မြ 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred A Natural 5 Pending injury 1 Yes 2 No Accident Director: / Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours

To the Funeral I

completed filled Medical M Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Virginia 29d. Date signed (Month, Day, Year) 06/15/2011 0101038 MD Emicu. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6900 Georgia Ave., NW Washington, D.C. 20307 Deborah Omori, MD. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 51 10PM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death LA PLATA CENEZIZ LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign NOM 2 DF Months (Month, Day, Year) 43 216-40-7588 WASH D.C. 69 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo CHARLES MD. LA PLATA X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1 MAGNOLIA DRIVE 20646 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. WHITE Specify: 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) UNION PAINTER PAINTERS UNION 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 LAWRENCE GREGERSON MARJORIE KOTTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON GREGERSON-DAUGHTER 403 BIDDLE RD. ACCOKEEK, MD. 20607 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 22. Name and Address of Facility
RAYMOND FUNERAL SI
LA PLATA, MARYLAND 21. Signature of Juneral Service Licensee M00479 Part 1. Enter the disease, or complicat of that caused the death. Do note the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 toi lure Sequentially list conditions, if any leading to a model cause. Enter Underlying Cause (Disease or iinjury that initiated events Disk to for as a nonsecutions of burial-transit resulting in death) Last Due to (or as a consequence of). attending physician for use as the burial Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Box Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 s performed' Yes 2 2 🗌 No 1 Tes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \square Yes 2 1 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner a Ceath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olony ridewater DA. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10, 2011 Dale F. Grinder 7:30 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Frederick Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Feb I, Day, 1931 1 🔯 M 2 🗆 F Months Hours 60 Washington, D.C 220-66-8894 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Frederick Brunswick Maryland Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21716 USA 1100 Peach Orchard Lane and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, et þ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Vending stand manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F ္ဝ Marion Frances Bowie Albert Francis Grinder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trac Rebecca Titus - sister-in-law 20842 6327 B. Dickerson Road, Dickerson, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 Burial 2 K Cremation 3 Removal from State 6-16-2011 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, UNC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Whursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director; A 2 Accident Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 FREDEVELLE 21701 TOIL HOUSE TIBLE A- KAZMI 814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06/09/201 RALPH FRANK GEORGE, SR. 10:56 AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
DC 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Min Months 09/07/1947 **Director** 220-54-2491 63 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shorex Examiner must be notified at 10c. City. Town or Location Director 1 XYes 2 ☐ No MD Montgomery Germantown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with USA 13511 Deerwater Drive 20874 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene. Maryland State Elementary/Seconday (0-12) College (1-4 or 5+) the 12th Laborer Supervisor Highway Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank George Lucille Johnson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is unique or extension Ralph F. George, Jr./son 9407 Quill Place, Montgomery Village, MD 20886 Baltimore, 20a. Method of Disposition Race of Disposition (Name of 20c. Location - City or Town, State etery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from 4 Deniation 5 Other (Specify) Cremation Svc | 06/14/11 Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 21. Sign kure of Funeral Service L 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or conshock, or heart failure. List only noations that caused the death one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Ph. sician/ Non small cell lung cancer disease or condition resulting in death) Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Due to (or as a consequence of): Exami executed resulting in death) Last Due to (or as a consequence of): physician a the burial-Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law Jas autopsy page death? certificate 2 X No Yes 2 X No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? iniury 5 Pending s after death.

I Director: Aff
d in by the fur 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours after

To the Funeral Direct

completed filled in b determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 7/2009

30. Name and addres

Geoffrey

31. Date filed (Month, Day, Year)

Coleman

of person who completed cause of death (Item 23a) (Type, Print)

32

1355 Piccard Drive,

gistrar's Signature

D37142

#100, Rockville, MD 20850

06/09/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Day Physician/ 201 T June 11:00P M Richard M. Grigsby Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Annapolis Heart Homes 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 💢 M 2 🗆 F Bunta) Ju Month, Pay3 Year 1918 92 579-18-3154 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 3446 Cohasset Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces? 1 X Yes 2 \(\text{No}\)
If Yes, Give
Year or Dates \(\text{1.943} - 46 \) þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ¥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) D.C. Elementary/Seconday (0-12) College (1-4 or 5+) Metropolitian Police Government Officer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mazie Gains Unobtainable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3446 Cohasset Ave Annapolis, Md. 21403 Richard M. Grigsby (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 6-16-11 Crownsville, Md. Maryland Veteran 4 ☐ Donation 5 ☐ Other (Specify) W.Mame a Research facilitSons Mortuary, 21. Signature of Funeral Service Licenses Larry 1922 Forest Dr. Annapolis, Md. 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final AILATES Ph_sician/ TAKIVE 70 G MANTHS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SAKS CMENTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine CRCBRAVASCACAR Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 1 ☐ Live Birth 2 ☐ Feet 52... 4 ☐ Pregnant at time of death 3 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day ģ 1 Yes 2 L g Unknown Yes 2 No is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ORONARY ARTERY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an AR CEREBREVASENC autopsy performe page 2 death? PARUXYSMAL ATRIAL KIBRILLATION 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျင 1 Inpatient 2 ER/Cutpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After 1 🔀 Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13, 2011 447494

Registrar

State

1616

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ANGSTON

32. Registrar's Signature

KORSST

ANNA TEUIS, M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a

JUN 1 5 2011

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ June 15, 2011 8:35 P M Milton Edgar Hammer, Jr. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Sept 7. If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Months Hours 579 10 3249 91 Washington DC **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at anone. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Temple Hills Prince George's Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20748 4415 Harvest Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc 1 Yes 2 No WII 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Social Worker DC Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Padgett 2 Florence Milton Edgar Hammer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4415 Harvest Road, Temple Hills, MD 20748 Jean Etta Hammer (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 18, 2011 Clinton, MD Lee Crematory 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Signature of Fu MO1140 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin such as cardiac or respiratory Approximate shock, or heart failure. List only one ca Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) to (or as a conseque ce Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day Pregnant at time of death the the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 - Yes 2 No ည 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) patient 28a. Date of injury (Month, Day, Year) funeral 27. Manney of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. iniury 1 Natural 5 Pending 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nursa Practioner: To the best of my knowledge eath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and til 30. Name and add 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10, 2019 7:20 a м Mary Lucille Howard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6915 Prout Road Anne Arundel Friendship 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖊 F Months Days Hours Min Country) MD Director 79 September 11, 1931 216-30-8515 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6915 Prout Road 20758 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Unit Secretary **Health Care** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Noble Brown **Dorothy Mullen** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6915 Prout Road, Friendship, MD 20758 Priscilla Mackall - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Carters UM Church Cem. June 17, 2011 any injury or 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State Friendship, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Sewell Funeral Home, P.A. 22. Name and Address of Facility Blady a.A 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARKINSON'S disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-transit that the death certificate be executed UP that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, The law requires 2 ✓ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No or Attending Physician: pleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD037511 6/14/11

Registrar

DHMH 17 Rev 7/2009

State

1160 YARNUM St, NE, DC-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEEPA, BALASUBILAMANIAM

2011>

JUN 16

32. Registray's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Inna Lucille Herbert 11:50 A ^M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles County Nursing Center LaPlata Charles Social Security Numbe 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M 2 🕱 F Months Hours Min. 578-22-1739 88 D.C. Director Jan 6, 1923 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MDAnne Arundel Churchton 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5602 West Carvel Drive 20733 U.S.A 2 should be filed within 72 hours after death with and Mental Hygiene.
27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🗓 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Owens Susan Harrison I and 2 should b I Health and Mei Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Lee G. Herbert/Son 5181 Old Solomons Island Road, Lothian, MD 20711 or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date ■Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 06/21/2011 Suitland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Alzhei mer enen disease or condition Medical resulting in death) Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be 68760 attending p IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 X No a 🗌 Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 e Hospital or Attending Physician: 1 124 hours after death. e Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred iniury 1X Natural 5 Pending Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Vithin 2 only one 29b. Signature an title 29d. Date signed (Month, Day, Year, 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRW 4327 Canada Hills Court, Waldorf, MD Dr. Husain 31. Date filed (Month, Day, Year) State 32. Registra s Signature

DHMH 17 Rev 7/2009

Please Type or Print In Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** 15, June 2011 6:30PM Thomas Gregory /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Frederick Northhampton Manor Health Care Center Frederick If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days Hours 10 M 2□ F 6/26/1946 New Jersey Director 579-78-4310 Usuel Residence of Decedent 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylend 10c. City, Town or Location 10a. Stete 10b. County the Medical Examiner must be notified at 1 Yes 2 □ No Directo <u> Maryland| Washington</u> Hagerstown or 28a-f 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number U.S.A. 21740 Herns 23a by Funeral 433 Brewer Ave. 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 Divorced Yeer or Detes: Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 6 Janitorial Vocational 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) item 27 is marked o C. Lutz Elsa 2 W. Hays Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) W.C.H.D.C. 433 Brewer Ave. Hagerstown, MD 21740 Bundrick / Agency Carmen 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or c 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/11 Smithsburg, Maryland Smithsburg Crematory 21. Signature of Juneral Service License 22. Name and Address of Fecility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Pert1. Enter the diseese, or complice shock, or heart failure. List only on **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death cartificate be executed use es the bunal-transit

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

cause on eech line.			
ATHERO SCLEROSIS	Conouncy	anteny	DISEASE-
Due to (or as a conse	quence of):		
DOWN STUD	Ro met		
Due to (or as a conse	quence of):		

Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably	4 Unknown

24a. Wes an autopsy performed?

26. Place of Death (C

24b. Were autopsy findings

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5 ☐ Residence	6 ☐Other (St

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1 🗆 Yes	21 3/ No

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examiner?	o
27. Menner of Death	
1 Naturel	5 🗆 P
2/ Accident	in

25. Was case referred to medical

5 Pending investigation 6 Could not be determined

Hospital: 28a. Date of Injury (Month, Dey Year)

MO

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 ursing Home 28c. Injury at Work? 1 Yes 2 🗆

	28d. Describe how injury occurred
No	

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only ons)

3 ☐ Suicide

4 Homicide

Completed by

Be

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edical Certification:

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as steted.

| Wedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 4795 29d. Date signed (Month, Day, Year) 06-17-2011

JW-Z

s efter dec.

To the Hospital within 24 hours e

filled in by

completaly

Division of Vital Records, P.O. Box 68760,

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) > IBTE A KAZMI, MM

814 TOLL HOUSE AVE

REDERICK

State

31. Dete filed (Month

Istrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 6:30 A M 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Washington Julia Manor Health case Haberstown 8. Date of Birth (Month, Day,) June 19 Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2 □ F Hours Min. Director Ĩ951 59 219-54-2657 Usual Residence of Decedent or 28a-f show ". Page 1 and 2 should be filed within remeant of Health and Mental Hyglene." hant If item 27 is marked other than "natural", or items 23a or 28a-1 shown and the cent, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 13 N. Locust Street Apt.-B 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes Give ri res, Give Year or Dates. Unknown 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Truck Driver Trucking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Barbara Elizabeth Brodice William Hummel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 N. Locust Street, Hagerstown, Maryland 21740 Jessica Harrison – Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State June 18 201 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home Hagerstown, Maryland 21740 415 E. Wilson Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** letastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). executed Cause (Disease or iinjury that initiated events hrowic Obestr burial-tran attending physician and resulting in death) Last Physician/Medical that the death certificate be 2000000 Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Dav To the Hospital or Attending Physician: The raw required some convince within 24 hours. (fer death, To the Funeral Director: Affer this certificate has been signed by the convenient of the con g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🗡 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify, 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) who completed cause of death (Item 23a) (Type, Print) -333 Mill Street, Hagenstown, MD 21740 TW-1 Blucher Nader. 31. Date filed (Month. istrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State	of Maryl		artment of F	Health and M Death		giene Reg. No.	p removied	21080
	Physicia	an	Registrar 1. Decedent's Name (First, Middle		_				2. Date of Dea		O 1 1 Year	3. Time of Death 1:45 A M
	/Medic	_	Blanche Cassar				Ab Oit Tour o	r Location of Death	June		ounty of Death	1.43 A
	Examin	er	4a. Facility Name (If not Institution	_	umber)						cheste	r
age of the	Funeral		4303 Cabini Creek Road								9. Birth	place (State or Foreign
	Director		220-36-4859	1 □ M 2 🛣 F	7	11 Yrs.	Months Days	Hours Min.	Jan. 2	9,1940	Mary	Tand
	pug »		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or L	ocation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r.i.ust be rotified at	ō	Maryland Dorche	ester			lock					1 □ Yes 2 🛣 No
7	the 1	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?
ζ [n with		4385 Cabin Cree	ek Road			21643				USA	
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?			in U.S. 13	. Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14	. Race - Ameri Black, White,	
Maryland 21215-0036	hin 72 hours after death with the Marylan 8. " matural", or items 23a or 28a-f show M. dical Evanitha is ust be redified at	by	1 ☐ Never Married 2 🏻 Marr 3 ☐ Widowed 4 ☐ Divorced		2 X No		1 □Yes 2 No					hite
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121	/ithin ne. han "	mpl	Elementary/Secondary (0-12)		(1-4or 5+)	Mana Mana	DO NOT use retire	d)		Assi	sted L	iving
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an	d be f ental ked o	To Be	Ralph Owen Smit					Mary Kat	hryn He	eard		
ary	es 1 and 2 should be filed i of Health and Mental Hygi of item 27 is marked other or other traumatic event, the	ř	19a. Informant's Name/Relations	hip (Type. Print)				t and Number or Ru				
	and 2 ealth a n 27 ii		Dennis M. Hard	ing/Husba				reek Road				
Baltimore,	Pages 1 lent of H nt: If iter ry or oth		20a. Method of Disposition 1 X Burial 2 Cremation 4 □ Donation 5 □ Other (S	3 Removal from			position (Name of ematory or other pla shington	Cem. 6/22	Date 2/2011		ock, Ma $^{ m cock}$	aryland
Balti	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of uneral Servi		00.		22. Name and Addr Celler Fur 06 Main S	ess of Facility Teral Home Street, Ea	e, P. O.	. Box Marke	207 et, MD	21631
		(3a. Part 1. Enter the disease, or shock, or heart failure. List			death. Do not e	nter the mode of dy	ing, such as cardiac				Approximate Interval Between Onset and Death
	Physician /Medical	ľ	Immediate Cause (Final disease or condition resulting in death)	a	OVA	nsequence of):	CANC	ニア				4 YEARS
e E	Examiner			550	0 (0. 40 4 50							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury	Due t	o (or as a co	nsequence of):						
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	ificate g physi s the l			d								
O. Box	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Liv	outcome of pige birth 2 ggnant at tim known	Fetal death	B ☐ Ectopic pregnan Control of the	icy		23	3d. Date of deli Month	very Day Year
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ds,	iires thai signed I d be det	d by	Tarrii. Other digitinount contact	one commodating to					1 🗆	Yes 2□	No 3∏ Pr	obably 4 Unknown
Record	w require s been sig should b	etec							24a. Was	s an	24b. Were au	topsy findings available
Se .	The law ate has page 2 s	Completed							auto	opsy formed?	death?	completion of cause of
Vita	iician: The certificate h ector, page	Be (25. Was case referred to medica examiner?					26. Place of Dea	th (Check only	one)		
of \	Physi this c		1 Yes 2 No			2 ER/Outpat	ent 3 DOA		lome 5 Res			cify)
uc	ding F h. After funera	ion:	27. Manner of Peath Natural 5 Pendir	ng (M	te of Injury onth, Day, Ye		/ Wo	ork? □Yes 2□No	Zou. Describe	: HOW IIIJUI Y	occarred	
Division of	I or Attendi after death. Director: A	Certification: To	2 Accident investi 3 Suicide 6 Could 4 Homicide detern	not be 28e. Pla	ce of Injury - ilding, etc. (S	At home, farm, Specify)	street, factory, office		28f. Location City or To	(Street and own, State)	Number or Ru	ural Route Number,
_	pita ours eral fille	Medical Ce	29a. Certifier Certifyi (Check only one)	Examiner: On the	the best of me basis of exa	amination and/or	eath occurred at the investigation, in my	time, date and place opinion, death occur	e, and due to thurred at the time	e cause(s) e, date and	and manner as place, and due	s stated. to the cause(s)
	To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of certific		anner stated		29c. Licer	nse number		29d. Date	signed (Monta	h, Day, Year)
	- 5 - O			X 24 A			-	2000-	7		1	2011

31. Date filed (Month, Day, Year)
JUN 2 0 2011 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DAVID SMITH, 8221 TEAL DRIVE, EASTON, MID 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jun 18, 2011 Physician/ 3:36 PM Jones <u>Ann</u> <u>Mary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Cumberland Manor 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sep 21 1 □ M 2 □,F Director 216-38-1601 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b, County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21502 229 Baltimore Ave., Apt. 201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 - Widowed 4 - Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Resturants Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Violet McCreary Benjamin Imes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip MD 21229 218 Mallow Hill Avenue Baltimore Stephen Imes brother Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Glendale Cemetery 4-21-2011 MD Flintstone 4 Donation 5 Other (Specify) 21. Synature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval_Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) moderale Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or consequence of) resulting in death) Last iis certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day 1 ☐ Yes 2 ≥ 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1-Hatural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical -Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) use 21, 00017565 person who completed cause of death (Item 23a) (Type, Print) Huy LaVele, MD 21502 ITSIlino Nat 1 MP 922 32. Registrar's Signature 31. Date filed (Month. Dav. Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 3. Time of Death 2 Date of Death . Decedent's Name (First, Middle, Last) Month 1,50 PM Kina 201 Physician/ TUNE Medical 4c. County of Death Teyn, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** aston Hospice HOUSE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday, Security Number Days (Month, Day, Yea. Min **Funeral** 1 M 2 F Months 7-05-8756 Ph. 22 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 10a. State Director 1 Wes 2 □ No ai Michae 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 6 2 tchel lo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 PNo should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or aumatic event, the Medical Exami Specify. Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Seafood Industry Elementary/Şeconday (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Be 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1662 19a. Informant's Name/Relationship (Type, Print) nthony 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) by Shore Crematon by College Curran Browwell 144. Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ambridge 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Frency Funeral Ho
510 washington 21. Signature of Funeral Service Licensee HOME, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year. wothelia Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a sonsequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day in the past 12 months? Pregnant at time of death 2 🗌 No g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 17 10 hemorrage 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 this certificate has performed 2 | No 1 Tyes Yes 26. Place of Death (Check only one) 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No မှ 28d. Describe how injury occurred 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 3 🗌 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 232 2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary S. DeShields, M.D. 509 Idlewild Avenue, Easton, MD

31. Date filed (Month, Day, Year)

37. Registrar's Signature

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ June 17. 9:42 Shirley Elizabeth Langley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 01/01/11 M 2 BB F Months Days Hours Min. Maryland Director 215-26-9491 80 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 93a or 98a.f. ***... 10a. State 10b. County event, the Medical Examiner must be notified at by Funeral Director 1 Yes 2 2 No Maryland Solomons Calvert 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 20688 60 Creston Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: White 3 ™ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry st grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Specify only highe College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Teresa Nies John William McKenzie and 2 should b Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20849 Chestnut Ridge Drive, Leonardtown, MD 20650 permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr. once. Bobbie Langley Herring / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 1 Burial 2 Cremation 3 Removal from State Solomons, Maryland 06/21/2011 Solomons UMC Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses P.O. Box 600, Lusby, MD 20657 Teven or complications that caused the d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myggardiel Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine to (or as a consequence of) e Hospital or Attending Physician; The law requires that the death certificate be executed 124 hours after death.

• Euneral Director; After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last oevtension Physician/Medical DID DONI Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ N⊠ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2- No 1 Inpatient 2 I ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Certificate: **U**⊠ Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 2 Acciden
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, Jato and Ja within 2 To the I unity utic) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, mo Hospita

State

Registrar

UAVId

31. Date filed (Month, Day, Year)

11IN 20

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1084

		•	State Registrar			Cer	tificate of L	Death		Reg. No.			
	Physicia	n/	Decedent's Name (First, Middle, JOHN		LANE,	Jr			Date of Dea Month	Day	Year	3. Time of D	
	Medic Examin		4a. Facility Name (if not institution,		,	01.	4b. City, Town, or	r Location of Death	JUNE		2011 nty of Death	5:15	AM
- A	LAGITITI		12900 Fox Bow I	Orive #101			Upper Ma				ice Geo	rges	
H	Funeral Director		214-46-0625	6. Sex 1 XM 2 F	e (In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da March 2	5, 1947	9. Birthp Coun M	place (State or i	Foreign
	show show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				1	0d. Inside City	Limits
	Maryla 28a-f s ptified	irect	MD Prince Georges Upper Marlboro									1 🗆 Yes 2	2 🖪 No
	e fied within 72 hours after death with the Maryland at thygiene. A superpose of the than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 12900 Fox Bow [Orive #101			10f. Zip Code 20774			10g. Citizen o	of What Cour	ntry?	
	death r items ner m		11. Marital Status	12. Was Decedent E Armed Forces?			Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ		
030	s after ral", or Exami	ed by	1 Never Married 2 Married 3 Widowed 4 - Divorced	Armed Forces? 1 XYes 2 If Yes, Give Year or Dates.	ETNAN	1-	☐ Yes 2 No	Specify:		Spec.	ify: E	Black	
9500-61212	2 hour "natu edical	Completed	15. Decedent (Specify only highes	's Education		6a. Deced		during most of work	ring	16b. Kind of	Business Inc	dustry	
77.	ithin 7 iene. r than the Mo	Com	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. D	O NOT use retired) La i	ndscaper		Lands	caping		
g	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Mg	To Be	17. Father's Name (First, Middle, La John Lane Sr.	ist)				18. Mother's Nan Eather S		Maiden Surna	me)		
Mar	of Health and Ment of Health and Ment of item 27 is marked r other traumatic e	ì	19a. Informant's Name/Relationshi	p (Type, Print) y Lane - sister		19b. Mailir 12 9	ng Address (Street a	and Number or Rui W Drive #1	al Route Numbe 01, Upper	r, City or Town Marlbor	o, State, Zip (20 7 74	
Baitimore,	Page 1 an nent of He ant: If iten ıry or oth		20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham Veterans Cem. 20c. Location - Complete Cheltenham Veterans Cem.								ham, N		
Bait	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Li	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A.									
F	hyninina		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line				ng, such as cardiac	or respiratory an	rest,		Approximate Interval Betw Onset and De	
م	Medical Examiner		resulting in death)	Due to (or as			IS TYPE I	т					
		Jer	Sequentially list conditions,	b. Due to (or as)9 IIIE I						
	uted nd ransit	Examiner	if any, leading to himiestate cause. Enter Underlying Cause (Disease or linjury that initiated events	с									
_	certificate be executed anding physician and use as the burial-transit	cal E	resulting in death) Last	Due to (or as	a consequen	ce of):							
0/8 	ificate ng phy as the	Medical	IF FEMALE:	_ u									
o n	death cer ne attendi ad for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	су		1	Date of deliv Month		ear
7. Ö.	s that the gned by t be detach	by		conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use c									
ras	require	eted							24a. Was			bably 4 🗶 U	
or Vital Records,	he law te has ! age 2 s	Completed							auto	psy ormed?	prior to co death? 1 \sum Yes	mpletion of ca	use of
<u>.</u>	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?	Ų				lace of Death (Chec		2 140	1 🗀 103	2 110	
<u> </u>	Physic this ca al dire	은	1 Yes 2 No	Hospital: 1 Inpati 28a. Date of inju		Outpatie	nt 3 DOA Oth	4 L Nursing H	ome 5X Resi			/)	
o uc	nding ath. r: After e fune	icate	1X Natural 5 ☐ Pending 2 ☐ Accident Investig	(Month, Day		injury	work	y at k? Yes 2 □ No	26d. Describe i	low injury occ	uneu		
DIVISION	al or Atte s after der il Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi			, farm, str	eet, factory, office		28f. Location (3 City or Tov		nber or Rura	l Route Numbe	er,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination ar	nd/or inves	tigation, in my opini	on, death occurred	at the time, date a	and place, and	due to the ca	use(s) and man	ner stated.
	Verith Com	_	29b. Signature and title of sertifier	NIN	111		29c. Licens			29d. Date sig			
			30. Name and address of person w	the completed cause of a	patri (Itam 00	Sa) (Typo I		D58171		JUNE 14	4, 201	1	
RI	41		NAVJIT K. GORA					ET NW, WA	SHINGTO	N,DC 2	0422/6	88	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ars Signature	A	hav.	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 June Catalina Angeles Lopez 8, 5:16 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov. | Pay, Year | 34 | 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Nicaragua 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 213-94-6821 76 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔼 No MD P.G. College Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9617 52nd Avenue 20740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. White 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Nicaraguan If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Miguel Molina Rosa Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Eunice Lopez/Daughter 9617 52nd Avenue, College Park, MD 20740 20a. Method of Disposition
1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of cemetery, crematory or other place)
Mt. Olivet Cemetery Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ි PramcTS^dges Cod¶ins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Septic Physician/ disease or condition Medical resulting in death) Examiner o days Sequentially list conditions, many, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No ō Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal disease 1 Yes 2 No 3 Probably 4 Unknown Completed Cormary Aftery 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy Vascular Peripheral 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

2

Hamover Parkway; Suite 104; Greenselt, MP 20770

dress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 24, 2011 Physician/ 1840 Lafferty Arvetta Mae Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** untry) WV 1 ☐ M 2 ☐ F Hours Manth 7 ay, 1932 Director 217-28-9141 78 Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Allegany Rawlings 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? o 23a Funeral 21557 USA 23657 McMullen Highway items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian Black, White, etc. 5 1 Never Married 2 Married þ within 72 hours after 1 Yes 2 No Specify. 3altimore, Maryland 21215-0036 Specify. "natural", 3 XWidowed 4 Divorced white Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Daisy Rinker Warden Coffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23657 McMullen Highway Rawlings MD 19a. Informant's Name/Relationship (Type, Print) 21557 Kathy Hafer daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ &remation / 3 ☐ Removal from State 6/26/201 Scarpelli Funeral Home, P.A. MD Cresaptown 4 Donatton 5 Other (Specify) 21. Sign ture of 22. Name and carreen Full Eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 05 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter orderlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ■ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ODKEER 24

Registrar

31. Date filed (Month, Day,

0 1 2011

12501 Willowbrook Rd Cumberland, Maryland 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ MARGARET LOUISE LINCOLN 2011 Ω 6 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 11 Virginia Avenue Cumberland A<u>llegany</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min Day, Year) Country Director 579-75-9682 Washington, D.(Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Allegany Cumberland 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11 Virginia Avenue 21502 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3
Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home 10 Homemaker permit. Page 1 and 2 should be filed w
Department of Health and Mental Hyg
Important: If item 27 is marked othe
any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Christopher Corso Rosalyn May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Foose / Son 414 George's Creek Boulevard, LaVale, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 06/10/2011 Cumberland, MD 22. Name and Address of Facility Upchurch Funeral Home, P.A. 21. Signature of Funeral Service Latenta e 202 Greene St., Cumberland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gun shot wound to the head sudden disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last by the attending physician tached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Malignant lymphoma, alcohol abuse within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 06/06/2011 6:30 P Subject shot herself 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Va Ave. Cumberland Residence Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 June 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D., Deputy M.E., 124 W. Third Street, Cumberland, MD Date filed (Month, Day, Ye JUL 0 1 201.1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201 Ĭ^{ear} Physician/ Day June 12 Dixie B. Murphy 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 6108 Cool Spring Terrace South Frederick 8. Date of Birth (Month, Day, Year) Feb. 2, 1939 If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏅 F Hours Indiana Director 316-38-6170 72 Feb. Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🛱 No Maryland Frederick Walkersville 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 105 Sandstone Drive, Apt. #221 21793 United States than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Noivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) +1^{College (1-4 or 5+)} Elementary/Seconday (0-12) and Mental Hygiene. Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Lily May Whitaker 17. Father's Name (First, Middle, Last) ပ္ Arval Brown 19a. Informant's Name/Relationship (Type, Print)

Monica Robyns /Daughter 19b. Mailing Address (Street and Nymber or Bural Route Number City of Town, State, Zinforde) 1701 6108 Cool Spring Terrace, Frederick, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2011 Frederick, Maryland Crematory Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21702 Ou 1621 Opossumtown Pike, Frederick, 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Peath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit Due to (or as a consequence of) resulting in death) Last bunal physician s the bunal Physician/Medical The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Pregnant at time of death 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Hospital or Attending Physician: Be (**Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Daughter Home Hospital Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD Drive; 46B 21702 Thomas Johnson 31. Date filed (Month, Day, Year) State strar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For Sitate Registrar	tate of Maryla		artment of F tificate of L		, ,	iene	Programme and	21089
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					Date of Death Month	h	Vear	3. Time of Death
	Medic	al	Laura Ann Scott Mar					June		2011	11:18 AM
	Examin	er	4a. Facility Name (if not institution, give street	and number)		_ '	Location of Death		1	ty of Death ederic	k
	Funeral		27924 Barnes Road 5. Social Security Number 6. Sex		last birthday)	Damasc If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign
	Director		154-36-4638	2 X F	63 Yrs.	Months Days	Hours Min.	06/16/1	1947	Coun	nJ
	nd how at	2	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	//ary/a 8a-f s tified	Director	MD Frederick	Dar	nascus						1 ☐ Yes 2 🏋 No
:	a or 2 a or 2 be no	ΙĒ	10e. Street and Number			10f. Zip Code		1	-	f What Cour	ntry?
	th with	Funeral	27924 Barnes Road		io lio	20872			USA		
	or itel	by Fu	x A	/as Decedent Ever in U rmed Forces? ☐ Yes 2 ☐ No			ispanic Origin? (Span, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ace - Americ lack, White, e	
3	irs afte iral", I Exar		o D wed-out A D Dissert	Yes, Give lear or Dates.	1	Yes 2 No	Specify:		Spec	fy: Whi	te
9500-612	"natu	Completed	15. Decedent's Education (Specify only highest grade control of the control of th		(Give I		ation during most of work	king	16b. Kind of	Business Inc	dustry
7	within /2 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Con	Elementary/Seconday (0-12) C	ollege (1-4 or 5+)	life. Di	O NOT use retired)					
.	요수등		17. Father's Name (First, Middle, Last)		'		18. Mother's Nam	ne (First, Middle, M	laiden Surna	me)	
yland	should be file and Mental I is marked of raumatic eve	은	Jack Kutzler		-		unkno		_		
			19a. Informant's Name/Relationship (Type, Pr		1		and Number or Run	·			Code)
ف	Tand f Heal item (1	Thomas Marley/husba	20b	. Place of Dispo	sition (Name of	Road, Dar			n - City or To	own, State
Ë,	Page nent o ant: If ary or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		. /	natory or other place Cremator	- 1	/2011 F	rederi	ck. M	D
baitimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.	- 0	21. Signature Juneral Service Licensee	Louis	/ 22	. Name and Addre	ss of FacilitySta	uffer Fu	neral	Homes	, P.A.
_			23a. Part 1. Enter the disease, or complication	Much			sumtown P			, MD	21702 Approximate
	Medical au and unal-transit	I Examiner	shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	nea					Interval Between Onset and Death	
DIVISION OF VITAL DECORAS, P.O. BOX 00/00	To the hospital of Attending Proposed. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1	yes, outcome of preg Live Birth 2 Fe Pregnant at time o	etal death 3 [of death 5 [Other (specify)				Date of deliver	Day Year
	signed be de	l by I	Part II. Other significant conditions contribu								ne cause of death? bably 4 Unknown
ecords,	been s	letec	Nicholes	Ans	nia	tewy d	z diasibe	24a. Was ar			psy findings available
Secondary Secondary	te has age 2	Completed by	Remonary Hyp	extension	1 0,5	hetre fost	e diaste	autops perform	ned?		mpletion of cause of
VII I	ertifica ctor, p	Be C	25. Was case referred to medical		1		ace of Death (Chec		Z LA INOI	T LL IES	2 🗆 🗤 🗸
5	this ce	၉	1 Nes 2 No	1 L Inpatient 2	1		4 ∐ Nursing H	ome 5 Reside)
0 7	th. After	cate	1 Natural 5 ☐ Pending	8a. Date of injury (Month, Day, Year)	28b. Time of injury	work	y at :? Yes 2 □ No	28d. Describe ho	w injury occi	urred	
	after deat Director: d in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At building, etc. (Spec			163 2 11 110	28f. Location (Str City or Town	reet and Nur , State)	nber or Rura	l Route Number,
	in 24 hours he Funeral pleted filler	Medical	29a. Certifier (Check only one) 3 Pertifying Physician: 2 Medical Examiner: 0 Trifying Nurse Pra	n the basis of examinat	ion and/or inves	tigation, in my opinio	on, death occurred a	at the time, date and	d place, and	due to the ca	use(s) and manner stated.
į.	With To the	97	29b. Signature and title of certifie			29c. Licens	number 55/dY		9d. Date sig	ned (Month,	Day, Year)
	01		30. Name and address of person was completed	ated cause of death (Ite	em 23a) (Type F		22/0(-0/1	1/6	V 1
	10			S. Main S		*	. Airy, M	ID 21771			
	Stat Registra		31. Date filed (Month, Day, Year) 3UN 1 5 2011	32. Registrar's Sign							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 14, Physician/ Harry William Neal 2011 9:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Clney Brooke Grove Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** July 25, 1 👿 M 2 □ F Months Days Hours Min. 82 North Caolina Director 242 36 8470 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 No Maryland 1 4 1 Olney Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20832 18404 Burtfield Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2XX Married Completed by Baltimore, Maryland 21215-0036 Yes 2 TyNo White 3 Widowed 4 Divorced Korean 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Laura Randall James William Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Neal (Wife) 18404 Burtfield Drive, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 6-23-2011 Cheltenham, MD . Sign ture f Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria zand mo0257 Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between 5 Drives Immediate Cause (Final PNELMONIA Pnysician/ ASPIRATION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DYSPHAGIA Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of, DISEASE -transit PARKINSON or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury END-STAGE that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a lor use as the burial-P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🗷 No Other: 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 🔀 Natural 5 \square Pending work 1 Tes 2 🗆 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRG+ WILLIAMSPURT, HOWE ARTIZAN 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

JUN 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per med cert G917 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Patrick Henry Nutter. June 16, 2011 III 8:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert 4100 Chesapeake Avenue North Beach 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 1**∑** M 2□ F Months Days Hours May 23, Director 220-96-7399 46 1965 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Wedical Examina 1, ust be restilled at Director 1 X Yes 2 □ No Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 Chesapeake Avenue 20714 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify. white 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) animal control officer Calvert County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Henry Nutter 2 Nancy Faye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 19a. Informant's Name/Relationship (Type. Print) Nancy F. Nutter, mother 420 West Dares Beach Road, #406, Prince Frederick, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 06/21/11 | Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee _8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure List only one cause on el ch line Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Acute V Mal Failure /Medical Due to (or as a consequence of): **Examiner** Nephropathi Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760. Physician/Medical romary IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? al or Attending Physiclan; Tis s after death. Il Director: After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 16, 2011 31 Name and address of erson who completed cause of death (Item 23a) (Type, Print) JRN J errinac (+ Prince Fuel W) Wi JOHN WOON 31. Date filed (Month, Day, Year) 32. Registrar Signature State JUN 17 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE Day 2011 Year Physician/ 8:13 P M 12 CHARLOTTE WELLS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6 Sex **Funeral** Hours May 10, Year 1916 1 🗆 M 2 🛛 F Months Washington D.C. 95 Director 579-38-3884 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Director 1 Yes 2 K No Maryland Frederick Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21771 United States 5803 Catoctin Overlook Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after in ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Robert Wells Charlotte Kerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3679 Ridgeview Road, Ijamsville, Maryland 21754 Patricia Woods / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ö Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 6/16/2011 Rockville, Maryland. Signatur Funeral Service 22. Name and Address of Facility
Stauffer Funeral Homes P.A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e on each line shock, or heart failure. List only one ca Immediate Cause (Final 5 Piration PNew moraca Ph_{sician/} 480 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) astro esopha burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year for Pregnant at time of death 1 Yes 2 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been 24b. Were autonsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy performed 1 🗌 Yes 2 🔲 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical director. examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Ashwa 31. Date filed (Month, Day, Year) strar's Signature 32. Rei JUN 1 5 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ph

56 Thomas Johnson DR ack

29c. License number

2011

Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 19 2:40 June 2.01 William Ralph Price Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 18303 Woodside Drive Hagerstown 8. Date of Birth Month Day, Year) July 21, 1935 9. Birthplace (State or Foreign If Under 24 Hrs 7. Age (In vrs. last birthday **Funeral** Months Hours 1 **X** M 2 □ F Maryland 217-32-6873 75 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 🗌 Yes 2 🔀 No Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21740 USA 18303 Woodside Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) **5+** County Public Schools Elementary School Principal Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Viola Pearl Hoffmaster Benjamin Wade Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18303 Woodside Drive, Hagerstown, MD 21740 <u>Jean L. Price / Wife</u> item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 106/22/2011 |Hagerstown, MD Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death eth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ 120 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Dav Year Pregnant at time of death 2 🗌 No Yes detached 9 Unknown Division of Vital Records, P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of geten su 24a. Was an autopsy performed death? certificate | Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ရ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 1 Natural
2 Acciden
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation after death Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the Hest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29d. Date signed (Month, Day, Year) and title of 29c. License number 29b. Signature BU 30. N line and address of person who completed cause of death (Item 23a) (Type, Print)

12+1 JN | State

31. Date filed (Month, Day Year)

32. Registrar's Signature

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			Plea	se Type or Pri							
			For	State of M	arylan			Health and N	Mental Hy	gienez []	21094
			State Registrar			Cer	rtificate of	Death		Reg. No.	-
	Physicia Medic		Decedent's Name (First, Middle DORIS	, Last) ELAINE		PAYN	E	<u> </u>	2. Date of Dea Month JUNE	17 2011 Year	3. Time of Death 3:00 A M
Same of the last o	Examin	er	4a. Facility Name (if not institution			or Location of Death		4c. County of Dea			
			819 CYPRESS POINT CIRCLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under						8. Date of Birt	PRINCE GE	rthplace (State or Foreign
2	Funeral Director									hington, DC	
	aryland a-f show fied at	Director	10a. State 10b. County	e croncels	ĺ	y, Town or Lo	cation		-		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he Me or 28; e notii		MD PRINC	E GEORGE'S	ъ	JWIE	10f. Zip Code			10g. Citizen of What C	ountry?
	with t	Funeral	819 CYPRESS PO	INT CIRCLE			2072	1		USA	
21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾	11. Marital Status 1 ☐ Never Married 2 💹 Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? ied 1 ☐ Yes 2 🛣			Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
5-0	2 hou "natu	plet	15. Deceder (Specify only highe	nt's Education st grade completed)		16a. Dece	dent's Usual Occu kind of work done	pation during most of work	ing	16b. Kind of Business	s Industry
121	thin 7: sne. than the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	5+)		ONOT use retired nemaker	during most of work)		Private	
-	be filed within ental Hygiene. 'ked other thai ic event, the N	To Be (17. Father's Name (First, Middle, L			1101			ne (First, Middle,	Maiden Surname) Washingt	on
Z	uld be d Men marke natic	-)avis		T		Selena	10 111 1		
Ma	12 should be file lith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationsl Robert L. Payr							r, City or Town, State, Z ie, MD 2072	
ē,	f Hea item		20a. Method of Disposition		20b. P	lace of Dispo	osition (Name of		Date	20c. Location - City of	
E C	Page nent c ant: If Iny or		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S				matory or other pla e Cremato	: 1.	21/2011	Riverdal	e, MD
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service L	icensee							AL HOME, INC.
			23a. Part 1 Enter the disease, or	complications that caused	d the deatl					VILLE, MARY	Approximate
-	Physician/		shock, of heaft failure. List of Immediate cause Chal	only one cause on each line	∍.		Cancer				Interval Between Onset and Death 2 years
	Medical		disease or condition resulting in death)	Due to (or as			Cancer				2 70015
	Examiner	<u>.</u>	Sequentially list conditions,	b. ———							
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	uence of):					
	executed an and rial-transi	Exai	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):					
0	e be ey ysician e buria	<u>a</u>		d							
876	tificate ng phy as the	Med	IF FEMALE:				·				
Box 68760	or Attending Physician: The law requires that the death certificate be executed affect death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	aldeath 3	Ectopic pregnar Other (specify) _	ncy		23d. Date of d Month	elivery Day Year
P.O.	that th	by Pr	Part II. Other significant condition	ons contributing to death b	out not res	ulting in the u	underlying cause g	jiven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
S,	w requires that s been signed t s should be det	ed b							1 🗆	Yes 2₺ No 3□	Probably 4 🗌 Unknown
Sor	aw red as bee 2 sho	Completed					-		24a. Was	osv prior to	utopsy findings available completion of cause of
Rec	sician: The law scrificate has t	lig.								rmed? death?	es 2x No
tal	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:				Place of Death (Chec	k only one)		
ί	Physic this c	은	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati		ER/Outpatie	nt 3 🗆 DOA			dence 6 Other (Spe	cify)
o uo	ending lath. Ir: After	Certificate:	1 ★Natural 5 ☐ Pendir 2 ☐ AccidentInvesti	ng <i>(Month, D</i> a gation	y, Year)	injury	wor	rk? ☐ Yes 2 ☐ No	28d. Describe r	ow injury occurred	
Division of Vital Records,	tal or Attending Physic rs after death. al Director: After this oc ed in by the funeral dire		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	28f. Location (S City or Tox	Street and Number or Fi vn, State)	ural Route Number,					
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu	Medical	(Check 2 Medical I only one) 3 Certifying	Nurse Practioner: To the	xamination	n and/or inves	etigation, in my opin death occurred at t	nion, death occurred a the time, date and pla	at the time, date a	and place, and due to the	cause(s) and manner stated.
	Not To 1		29b. Signature and title of certifie	Idatt. S			29c. Licens	se number D26250		29d. Date signed (Mor	
	2		30. Name and address of person	1	leath (Item	1 23a) (Time 1				June 1	1,0011
1	at a		Matilda So, M	.D. 1221 M	ercar	ntile 1	Lane, La	rgo, MD 2	0774		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	back	1				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carroll June Gernard 20T1 6:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Hospice Care Columbia Howard 8. Date of Birth
(Month, Day, Year)
Sept. 24, 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. Country) 220-28-2708 78 Director Sept. 1932 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 5320 Dorsey Hall Drive Apt 113 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 X No ş Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XXX No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy Injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) supervisor door & window mfg. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Leo Punt, Sr. Rachel Snowberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Punt son 10207 Raleigh Tavern Lane Ellicott City MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 06/24/2011 Cumberland Valley Waynesboro, PA 17268 4 Donation 5 Other (Specify) Cremator in and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Fundral Service Lightsee 50 S. Broad Street Waynesboro PA 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) WEEKS Medical Due to (o a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year the detached Division of Vital Records, P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s certificate has autopsy performed? Yes 2 No death? Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director, A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certific D64395 cocumbia, mo 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 CEDAR LANE DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ John Sr. F. Ryan 2011 P^M June 9:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Greorge's Hospital Center Cheverly Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** lay, Year) Country District 20,1930 of Columbia (Month, Day, Days Months Hours 1 X M 2 🗆 F 80 Director 578-36-5564 Sept. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland by Funeral Director 1 ☐ Yes 2 🏋 No Prince Georges Landover 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6710 El Paso St United States 20785 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1951 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify 1955 Specify. Completed | White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Patrick Francis Ryan Bridget McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Grace Ryan (Spouse) 1706 Veirs Mill Road, Rockville, MD 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o X Burial 2 Cremation 3 Removal from State June 14, Ft. Lincoln Cemetery Brentwood, MD 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licenses TRACHA. M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ocardia disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 attending p IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 A No 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou.. **the Funeral Direc..** Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29d. Date signed (Month, Day, Year) D2233 s of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Darke 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 Day 2011 Year Physician/ JUNE JOHN ALBERT REHFUSS, SR. 10:45 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1075 Sandy Bottom Rd. Earleville Cecil 7. Age (In yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign Social Security Numbe 8. Date of Birth Funeral Aug 24 1 🛛 M 2 🗆 F Months Days Hours ^{Year)} 1937 214-36-9705 Maryland **Director** 73 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature." 10d. Inside City Limits 10c. City. Town or Location Director MD 1 🗌 Yes 2 🔀 No Cecil Earleville 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 1075 Sandy Bottom Rd. 21919 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Yes 2X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile College (1-4 or 5+) Elementary/Seconday (0-12) Forklift Operator 12 Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Michael Rehfuss Agnes Moffett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Rehfuss (wife) 1075 Sandy Bottom Rd. Earleville, MD. 21919 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Cremation 3 Removal from State 1 🔀 Burial 6/29/11 Old Bohemia Cemetery Warwick, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. 23a Part 1 Enter th Approximate Interval Between Onset and Death Bladder Immediate Cause (Final disease or condition CA Physician Medical resulting in (eath) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediat cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Cos to for ea a consecuence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. burial-transit Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Multiple Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5X Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 🔀 5 Pending 1 🔲 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 0 ress of person who completed cause of death (Item

Registrar

State

. Date filed (Month, Day,

1217

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun 24, 2011 **Physician** 4:10 AM Shirley Lee Ralston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Cumberland Golden Living Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Funeral 6. Sex 1 □ M 2 □ F Days Months Hours Min. 1930 MD Director 215-26-9341 Oct 1, 80 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Exerciner must be notified at once. 1 □ Yes 2 □ No MD Allegany Cumberland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 USA P.O. Box 822 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ **X**Io 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □**X**lo If Yes, Give Year or Dates: Specify 2 Specify: 3 KWidowed 4 Divorced white Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Schwab Company Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rhoda V. Lease George G. Cecil ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Christopher Yoder grandsoh Cumberland 630 Maryland Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Buriat 2 ☐ ★ emation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (\$pecify) Scarpelli Funeral Home, P.A. 6/25/2011 MD Cresaptown 21. Signature of Funeral Servic Licensee 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Year's /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No ned by the 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 3 Probably 4 ☐ Unknown cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No Completed Was a autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Anursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A filled in by the fu death. 2 Accident 6 □ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at within 24 hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ise of death (Item 23a) (Type, Print) Camberland, Md 21502 10000

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 15. 2011 10:30 P M Charles J. Snyder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Months (Month, Day, Washington DC 577 32 8999 83 **Director** Usual Residence of Decedent Fshow or 28a-f shov notified at 10a. State 10b. County 10d, Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 🗆 Yes 2 📈 No Maryland Prince George's Clinton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? r must be r Funeral 8004 Colonial Lane, 20735 United States "natural", or items? 12. Was Decedent Ever in U.S. Armed Forces?

1 to Yes 2 □ No WIII 1f Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 ▼ Widowed 4 □ Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed with... th and Mental Hygiene. 27 is marked other than "r ""matic event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Car Repairman/Amtrak Railroad Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Ezra Allen Snyder Marguerite Mundell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 Colonial Lane, Clinton, MD 20735 Theresa Dickerson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery June 21, 2011 Clinton, MD re of Funeral Service Lice 1013 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE CEREBROVASCULAR ACCIDENT Phylician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for Month Day 5 Other (specify) Pregnant at time of death the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNOUMONIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy perform certificate 2 1 No 1 Yes Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) . Mann of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA 0064986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 285 31. Date filed (Month. strar's Signature State JUN 20 Registrar

11-04327 - Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Daniel John Sohovich, II State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 0 0										
		1-For State amend #21 Per DVR G91 <i>CeHtffich(201</i> 4) Registrar	∮eath		eg. No.					
Physicia Medical Examii	n/	1. Decedent's Name (First, Middle,Last) Daniel John Sohovich, II	j	Date of Dea Month une 9, 20	Day 011	Year	3. Time of Death 0343 hrs			
		4a. Facility Name (if not institution, give street and number) Polling House Road @ Windsor Farm Road	o. City, Town, or Location of Death Harwood			County of Death nne Arundel				
Funeral Director	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY									
7 any	mpleted by Funeral Dire	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			T	10d. Inside City Limits 1 Yes 2 X No			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Maryland Anne Arundel Edgewater 10e. Street and Number	10f. Zip Code	1	10g. Citiz	zen of What Coun				
the Mine or 2:		2115 Millhaven Drive	21037			USA				
with ms 23.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Specifics, specify Cuban, Mexican, Puerto Rica	fy Yes or No	D-	14. Race - Americ White, etc.	an Indian, Black,			
r death		1 Yes 2 X No		a., o,		Wha	te			
s after		or Dates:	res 2 No specify: s Usual Occupation (Give kind of work	done		Specify: W111				
2 hour			st of working life. DO NOT use retired)				,			
D36 thin 7:		3 Studen	t		E	Education	1			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)	18.Mother's Name (Fir		Maiden	Surname)				
121 d be fi lental arked		Martin Sohovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Vera Jame Address (Street and Number or Rura		mhor Ci	ty or Town State	Zin Code)			
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and 2 and 2 fealth from 2		20a. Method of Disposition 20b. Place of Dispositi	ion (Name of cemetery, Da	ate		Location - City or				
nord		1 X Burial 2 Cremation 3 Removal from State crematory or othe Our Lady of S	Sorrows Cemetery 6—14-	-2011	We:	st River	, Maryland			
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Na	me and Address of Facility Geor	-						
E De C			3 Solomons Island							
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	mode of dying, such as cardiac or re	spiratory ari	rest, sho	ock, or neart	Approximate Interval Between Onset and Death			
LAAIIIIIC		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.								
ecuted and transit	Examiner									
e exec	dical	UNPENDED AMENDED								
760, ficate be exe g physician	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Feta	if death 3 Ectopic pregnancy	,	230	d. Date of delivery Month D	ay Year			
Box 68760, death certificate be the attending physic of for use as the burned for use as	Physician/Medic	past 12 months? 4 Pregnant at time of death 5 Other	al death 3Ectopic pregnancy		1	WOTHER D	ay rour			
b. Bc the dea	Phy	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did t	obacco	use contribute to t	he cause of death?			
ords, P.O. we requires that the as been signed by to should be detache	d b			1 Ye	s 2 🗸	No 3 Prob	ably 4 Unknown			
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of Vit. ing Physici After this c	To E	1 ✓ Yes 2 No Inpatient 2 ER/Outpatient				ence 6 Other	Scene			
Division of Vital Records, rate attending Physician: The law requir rs after death. In Director: After this certificate has been sted in by the fumeral director, page 2 should		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day, Year) Jun 9, 2011 0328 hrs		bject vee		ary occurred ff curve at hig	h speed and hit a			
Divisior Bospital or Attend 24 hours after death. Funeral Director: stely filled in by the	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rui or Town, State) Pulling House Road @ Windsor Fa								
Hospi 24 hou Funer etely fil	-	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only)								
To the within To the compl	Medical	29b. Signature and title of certifier 29d. Date signed (Moc								
		I the Solaton Sept 100	O.C.M.E.		Jun	e 9, 2011				
Ky, C		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
	ate	24 Data filed (Month Care Vocal and S.A. 32 Registraris Signature &	uli							
Regist	ueu									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Month 10:30 Nathan Jesse Souders, Jr. 201 Tune Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days April 14,1921 219-05-2521 1 X M 2 □ F 90 Yrs. **Director** Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death when we refer and Mental Hygiene.
I Health and Mental Hygiene.
I them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Keedysville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18122 Keedysville Rd. 21756 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Machinist Pipe Organ Mfg. 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Jesse Souders, Sr. Catherine B. Souders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue ellen Souders-daughter 10510 Hershey Dr. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Cedar Lawn Mem. Park 6-24-2011 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) |Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. September of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition with the cause of the cause (Final disease or condition to the cause of the cause (Final disease). Approximate Interval Between Onset and Death Physician/ NNEVMONIA Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTIVE LUNG DISPITE CITAMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami sician and burial-transit The law requires that the death certificate be executed DBILLITY Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 1 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accider
3 Suicide injury 5 Pending 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) 046561 Jane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bookingone CAPPANS ROAD GITTUM 20311

DHMH 17 Rev 7/2009

State Registrar Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DRINGER 0300 AM 06 CA 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health (JuliaManian Housevestown Washington 5. Social Security Number 6. Sex Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 24 Hrs Funeral If Under 1 □ M 2 🏋 F Min. Sep 5,1928 212-24-3556 82 Marvland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar minst he material and injury or other traumatic event, the Medical Examinar minst he material and injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 828 Chestnut St. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Department Store 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry C. Springer Minnie G. Pittsnogle Springer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Barron-niece 445 E. Oak Ridge Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 6-22-2011 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ SQUAMOUS Medical resulting in death) Due to (or as a consequence of) Examiner Dhoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed prontage attending physician and Due to (or as a consequence of): Physician/Medical) abetos IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 X No မှ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 Mill Street, Haberstown IW-5 Naden-Blucher, State Registrar

DHMH 17 Rev 7/2009

Box 68760

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2/011 June 13, Rose Schomberg 12:50 P™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Gaithersburg Nightengale House 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🖾 F Hours Feb. 7, 97 **Director** Pennsylvania 162-10-3822 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director 1 Yes 2 X No Maryland Gaithersburg Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20878 United States 12213 Bradbury Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by ō 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 🔀 Widowed 4 🗌 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) P Martha Joseph Shalitta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12213 Bradbury Dr., Gaithersburg, MD 20878 Paul Schomberg / Son item 2 20a, Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or otl 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State June 15, 2011 Frederick, Maryland Resthaven Crematory 4 Donation 5 Other (Specify 21. Signature of Juneral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Onset and Death Physician/ Cellulitis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner months Multiple Decubitus Ulcers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Advanced Alzheimer's Dementia years certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 X No. g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hypertension 1 ☐ Yes 2 XX No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕱 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury 1 XX Natural 5 Pending after death. Accident Investigation 1 Yes 2 No the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 1 🔉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0058844 June 14, 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20407 Seneca Meadows Pkwy., Germantown, MD 20876 Jose De Leon Carpio, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. An 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Physician/ Month Day Stauder Francis 0, 7:55 Ronald <u>June</u> Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 07 Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5, 1928 9. Birthplace (State or Foreign Country)
Missouri Funeral Social Security Number 7. Age (In yrs. last birthday) Days 1 X M 2 □ F Hours 491-26-9126 **Director** 83 Usual Residence of Decedent or 28a-f show notified at 2011 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral 16605 S. Westland Drive United States 20877 しなった 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. 1 Never Married 2 X Married ρ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 ☐ Yes 2 X No Specify Specify: 3 - Widowed 4 - Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other trammer. 5+ Physicist Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Webster Dorothy Joseph Francis Stauder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Joan Stauder/Spouse 16605 S. Westland Drive, Gaithersburg, MD. 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/11/2011 Metropolitan Crem. Alexandria, Virginia 21. Signature of Funeral Service Lice, s 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Physician/ Myocardial hours disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Dav Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: performed? Yes 2 No the Hospital or Attending Physician: The Ithin 24 hours after death.

the Funeral Director: After this certificate himpleted filled in by the funeral director, page 2 XNo 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 TER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural 2 injury 5 Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockville, Md. 20350 8+1VA Buz 9901 31. Date filed (Month, Day, Year) State JUN 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Adrian Joseph Simi Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year) Director 85 579-22-2712 Washington, D.C Usual Residence of Decedent show 10a. State 10b. County of Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ADAHAN Funeral 13400 Idlewild Drive 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 X Married If Yes, Give 1943-46 1 Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gaudenzio Simi El ena Giannini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene S. Simi/Spouse 13400 Idlewild Drive, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Maryland Veterans Cen. 6/17/2011 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Emeral Sen 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. 23t 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final Ph_sician/ 100Gration disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Acidosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed No death? 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) NO ddress of person who completed cause of death (Item 23a) (Type, Print) ROAD, LAWHAM, MD 20706 8118 MO

3. Time of Death

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

Year

2 No

1X Yes 2 No

D

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

JUN 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 12, Physician/ 2011 Рм 6:00 Nicholas M. Short, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Collington Episcopal Life Care Center Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 18 1927 83 Missouri **Director** 491-26-0298 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 □ No Mitchellville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10450 Lottsford Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **8+** Elementary/Seconday (0-12) NASA Research Scientist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Harry E. Short Dorothy Martin other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 14436 Old Stage Road Bowie, MD 20720 Nicholas M. Short, Jr./ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Washington 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/15/2011 | Laurel, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 207<u>15</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death vostate Immediate Cause (Final metastasis CavcinomA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ladde Carcinoma osquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mellitus. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv page 2 perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral within 24 hours after death. To the Funeral Director: After iniury 1 Natural 5 Pending Investigation Accident 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0042049 14,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD hampaloux MD. Alain Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ Month 0245A M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 1174 W. Central Avenue Davidsonville Year If Under 24 Hrs . Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Mir (Month, Day, Year) 05/06/1946 Director 217-46-9440 65 Washington, DC Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Davidsonville Maryland | |Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1174 W. Central Avenue USA 21035 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify. Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Investment Advisor Commercial Real Estate injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alfred Steiner Daisy Terish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Elizabeth Steiner / wife 1174 W. Central Avenue, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Cemetery 06/16/2011 Davidsonville, MD 21. Signature of 5 22. Name and Address of Facility George P. Kalas Funeral Home MI 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final ANC nset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin Cause (Disease or iinjury that initiated events resulting in death) Last trar Due to (or as a consequence of) Physician/Medical death certificate be phy: IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autops perforn 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral n 24 hours after death.

le Funeral Director: After th

bleted filled in by the funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print) no completed cause of death (Item (Type, Print) DEFENSE HUS, ANNAPOLIS, M.D. 2140 7 GHTTOOI 31. Date filed (Month. 32. Registrar's Signature State 5 2011 Registrar

Baltimore. Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician/	Decedent's Name (First, Middle,Last)								Date of Death Month Day Year			3. Time of Death	
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Funeral	5. Social Security N	lumber 6. Sex	7. Age (In yrs. las		f Under 1 Y			. Date of Birth	h (MM/DE	O/YYYY) 9. Birtl	nplace (State or	
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5-0036 ed within 72 hour itygiene. inther than "natt the Medical Exa	Liomoniai y/ococ	31GG19 (0 12)	4	´	GENER!	AL MAN	IAGER			BEVI	ERAGE S.	ALES	
5-00 lied wi Hygien Inthe Cor		(First, Middle, Last)					18.Mother	s Name (Fi	rst, Middle, M	laiden Su	ırname)		
2121 bould be fil d Mental I is marked tic event,	NELSON T	ICE SIEGE			19b. Mailing Ad	ldress (Str			TVRDII		or Town State	Zin Code)	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Heath and Mental Hygiene. Inst: If item 27 is marked nither than "natural", nr items 23a or 28a-f shur other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		IEGEL/WIF		- 11		•			RNOLD,			Zip oddoj	
re, lead the street of transfer transfe	20a. Method of Dis	position X Cremation 3	Removal from State	20b. Pla	ace of Disposition	n (Name of o	cemetery,	D	ate	20c. Lo	cation - City or	Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienc. Important: If item 27 is marked nither than "natural", nr items 23a nr 28a-f shun injury or other traumantic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 Donation 5	Other Specify:		7 8 ER	ace of Disposition ematory or other SAPEAKE TER				3/2011	STE	VENSVIL	LE, MD	
Balf permit Depart Impor injury	21. Signature of Fu	peral Service License	- //	1	22. Nam HELI	e and Addre	ess of Facility	LAST]	NG TR	FBUT	ES BYNE	ELLOWS RALLOWS	
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/Medical xaminer	Immediate Cause (failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Injuries Between Onset and Death Death											
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1876 rtificat ing phy as the	IF FEMALE: 23b. Was decedent past 12 months		23c. If yes, outcome 1 Live birth	of pregna	ancy 2 Fetal o	death :	3 Ectopic	pregnancy			Date of delivery lonth D	ay Year	
b. Box 687 the death certification by the attending probe of or use as the Physician//	1 Yes 2		4 Pregnant et til	ne of deat	th 5 Other	(Specify)				1			
o. B It the d lby the		ficant conditions	contributing to death t	out not res	ulting in the unde	erlying caus	e given in Pa	nrt I.	23e. Did tot	bacco us	e contribute to	he cause of death?	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the stater death. al Directur: After this certificate has been signed by led in by the funeral director, page 2 should be detach errification: To Be Completed by P								1 Yes 2 No 3 Probably 4 Unknown					
Records, The law requires fricate has been significate by age 2 should be Completed								autopsy prio			opsy findings available ompletion of cause of		
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ital Recidion: The scrifficate rector, page	25. Was case refer examiner?	Ho	spital: 1 Inpatient	ع ا	R/Outpatient 3		Other	(Check only Nursing H		Posidona	ce 6 🗸 Other	Soons	
n of Viving Physical After this Vineral dir.		2 No	28a Date of Injury		28b. Time of Injur		njury at Work	? 28	d. Describe h	ow injury	occurred		
ion tendin leath. The fu	1 Natural 2 Accident	5 Pending Investigation	FOUND: Day,Yea		FOUND: 1130 hrs	1	Yes 2	No Su	bject jumr	nped c	off bridge		
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	3 🗹 Suicide	6 Could not be determined	28e. Place of Inju	ry - At hon	ne, farm, street, f	actory, offic	e building, et	- 1	or Town, St	tate)		al Route Number, City	
Iospita t hours ty fille	4 Homicide Pour Bay P												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcral Directur: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Image: Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
E > E 8	29b. Signature and		04 0 0		·		ense number	-			ate signed (Mor	oth, Day, Year)	
	Car	al #	alla	in		0.0	C.M.E.			June	10, 2011		
ITA	30. Name and addr Carol Allan,	ess of person who co	mpleted cause of deat t Medical Exam			ore Stree	et, Baltimo	ore, MD 2	21223				
State	31. Date filed (Mon		32. Registrar's	Signature	34 4								
Registra		JUN 1 5 201	Geneu	U	9. span								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 17 . 2011 6:00pM Charlotte Clare Snyder Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Howard 9853 Diversified Lane Ellicott City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign . Age (In vrs. last birthday Funeral Months 1 M 2 X 8/18/1959 Virginia 51 Director 227-64-2418 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director Examiner must be notified 1 Yes 2 No Ellicott City Md. Howard or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 9853 Diversified Lane 21042 or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black White, etc. þ 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 72 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 4yrs Homemaker other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of မ Wilma Lindsev Robert Logan Clare Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9853 Diversified Lane Ellicott City, Md. 21042 Michael Roy Snyder/husband 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 6/22/2011 Crest Lawn Memorial Marriottsville, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. re of Muner ice Lic MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PEAR disease or condition resulting in death) Medical Examiner Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for us a consequence of Examir and -transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 death? Yes 2 X No Yes 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Hospital 2 **X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 A Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury XNatural 5 Pending 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

Registrar

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State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}2011 Physician/ June 19, 635 Tedrick Richard Arlington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington NMS Healthcare Hagerstown 8. Date of Birth (Month, Day, Year) May 4, 1925 9. Birthplace (State or Foreign 6. Sex 1 █ M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Funeral Days Min. Months Hours Marvland 86 Director 219-14-8718 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Tes 2 X No W.Virginia Berkeley Falling Waters 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 25419 USA 35 Hearthside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 3 Widowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Owner Operator Real Estate Company O 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve 2 Rhoda Bell Hawbaker William Carlton Tedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12910 Oak Hill Avenue Hagerstown, Maryland 21742 Barbara T. Robison (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park June 23,2011 Williamsport, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A. Ignama of Funeral Service License 425 S. Conococheague St. Williamsport, MD 21795 Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ Day Year in the past 12 months? Month Pregnant at time of death 2 No q 🗌 Unknown the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary Artery Disease autopsy has performed' 1 Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: <u>연</u>. Other: 2 🛚 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this
dilled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending M Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R118578 June 21, 2011 30. Name and address of person who completed/cause of death (Item 23a) (Type, Print) JW-4+1 Michelle Eyler 14014 Marsh Pike Hagerstown, Maryland 21742 31. Date filed (Month

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g917,07/15/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day / 4 Physician/ Yupa T. Ward Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Oct. 15, 1949 Yrs Thailand **Director** 61 005-70-2225 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland must be notified at Director 1 ¥ Yes 2 □ No MD Prince Georges Clinton 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral Thailand 20735 5801 Sulla Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Asian 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Mess Attendant</u> Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic s Tongdang Thamthieng traumatic Boonma Thamthieng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Sulla Ct., Clinton, Md., 20735 Harold A. Ward / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) June 25,2011 ALEXANDRIA, VA. Everly Crematory 22. Name and Address of Facility Everly Wheatley Funeral Home Fineral Service Licenses 21. Signature 1500 W. Braddock Rd. Alexandria, Va., 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death DISCR Ph sician/ roma 065 Truc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a attending physician for use as the burla Physician/Medical Records, P.O. Box 68760 CATION APPROVED BY ME IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed 020 orteoper oa certificate 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case ref ed to medical 26. Place of Death (Check only one) Be examiner? I Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral . Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? s after death.

I Director: After to in by the funeral 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in t 24 hours a hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 902

DHMH 17 Rev 7/2009

State

Registrar

Discatawa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRA

31. Date filed (Month

JUN 2 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day М IRENE S 2011 1:00P Medical TIME 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) March 20,1922 Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min Hours 1 M 2 Kentucky Director 579-20-9546 89 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛢 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6441 Jefferson Pike, 21703 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 2 No Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Head Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marcus Spear Ida Mae McFadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jasonya S. Enders, Niece 11919 Mid County Drive, Monrovia, Maryland 21770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place) Ar Ting ton National Cemeter 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery Unknown Arlington, Virginia 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 21. Signature of Fuveral A Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Chronic obstructive pulmonary disease Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed -transit Cause (Disease or linjury that initiated events resulting in death) Last Hematuria and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Pelvic Hematoma Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes 1 🗌 Yes page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension has autopsy perform death? after death.

Director: After this certificate 2 🗌 No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: မ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral L To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar

Mohammed Mohiuddin 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 110 Baughmans Lane Ste 201

PARTAGE A

32. Regis

MDD20015

Frederick,

6/13/2011

Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ 20T1 10:15a M Johannah E. Zimmerman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 0V • 4 • 1930 Hours 1 🗆 M 2 🕱 F Days Min 215-28-0726 80 Maryland Director Usual Residence of Decedent 28a-f shov 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Maryland Frederick Walkersville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 9731 Daysville Road United States ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 K No Specify: Specify: "natural", Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Own Home alth and Mental Hygie 27 is marked other in traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry G. Klamp Johannah Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health of If item 27 9731 Daysville Road, Walkersville, Maryland 21793 Ryan Zimmerman/ Son other 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Stauffer Crematory Inc.6/15/2011 4 Donation 5 Other (Specify) Frederick, Maryland. 21. Signatur uneral Service 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications th caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Renl Ph_sician/ milure year disease or condition resulting in death) Medical Examiner re tensio Sequentially list conditions. Due to Was a consequence of Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury trans and that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 the attending physician hed for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 Unknown n signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autons this certificate has page 2 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be ASSISTED GUINS examiner? Hospital Other: 2. No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After appleted filled in by the funer (Month, Day, Year) work?
1 \sum Yes 2 \sum No 1 Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🙀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schules

31. Date fled (Month, Day, Year)

7900

32. Registrar's Signature

Oak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dyr 9917 7-5-11 yt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20^Y1 Ethel Marie Armstrong 12:27 pM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland March 24, 1953 58 215-60-1350 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral USA 1022 Evesham Avenue 21212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2/ Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Specify: Black 3 Widowed 4 Divorced "natural" the of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Community Liason Univ. of MD. Medical Systems 2 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Merle G. Colburn Willie Davis, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Northwood Drive Baltimore, Maryland 21212 permit. Page 1 and 2 sl Department of Health a Important: If item 27 i any injury or other tra Ernest L. Murphy, III. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Brooklyn, Maryland 7/2/2011 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Foneral Service Licenses 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Arra Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and de detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medi-26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ၉ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manne Heath 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending Natural 2 Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after
To the Funeral Direc determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 5 29d. Date signed (Month, Day, Year) 0426500N 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital 5601 Loch Raven Blvd. Baltimore, Md. 21239 Teresa Muns 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Year -Month **Physician** 28 Cal 20 MONO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 □ F **Funeral** Days Jan 18, Mary Tand 217-38-0769 70 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No Director items 23a or 28a-f s er must be notified Dunda 1k Baltimore Mary land 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21222 United States of America 403 Wise Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ö Specify: White Yes. Give ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education item 27 is marked other than "natu other traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 + School Teacher Baltimore City Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental His marked of Ollie E. Avaritt Mamie Dabrowska ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Miriam V. Avaritt Wife 403 Wise Ave Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation of J 3 Removal from State = 5 permit. Page Department of Important: If any in]ury or Hilltop Service Corp. June 30, 2011 Towson, Maryland 5 Other 21. Signature of Funeral S Durana Rack Admer at Tarthome of Dundalk, Inc. w 7922 Wise Avenue Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 14more disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EUKC MIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 VNo 1 Yes Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury or Attending 1 ☐ Yes 2 ☐ No M death. Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anans 600 North Wolfe St, Baltimore, MD, 21287 OBIND

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed_(Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ERIN 2133 PM JUNE Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMURE UNIVERSITY OF MARYLAND MEDILAL CONTER 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 34 Months Hours Min. oct. 13, ^{Year)}197<u>6</u> ^{Co}Maryland 219-06-3574 Director Usual Residence of Decedent or 28a-f show notified at 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 21227 United States 5609 Chelwynd Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) HVAC Office Manager Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မ Doreen Morsberger Donald Severe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Breland - Husband 5609 Chelwynd Road, Baltimore Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory Jul.4,2011 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ END STAGE LIVER DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death ☐ Pregnant☐ Unknown been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 M No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 Matural iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) P2556 June 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GREENE STREET BALTIMORE KAMI HU 21201

DHMH 17 Rev 7/2009

State Registrar 11-04794

Steven Kenneth Byron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Mary	land / Depa	rtment of h	Health and	Mental	Hygiene

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Physici		1. Decedent's Name (First, Midd	le,Last)						of Death	V		3. Time o	f Death
/ledical Exami	dical Examiner Steven Kenneth Byron June 27, 2011							'	1636	hrs			
		4a. Facility Name (if not institution	on, give street and n	umber)		lb. City, Town, or	Location of De	ath		4c. County of			
		520 Forest Lane				Catonsville				Baltimor	e Cou	nty	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year				M/DD/YYYY			ate or
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any		10a. State 10b. County		10c. City, To	own or Locati	on						10d. Insid	de City Limits
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0036 within 72 hours after death with the Maryland jone. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Director	520 Forest La	ane			2	1228			Unite	d S	tates	3
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timore, MD 21215 t. Pages I and 2 should be file frment of Health and Mental H, rtant: If item 27 is marked o y or other traumatic event, th	ı	1 Burial 2 Cremation		TOTTI GIAIC	ematory or oth antic	Cremator	v 7-	-1-20	11	Glen H	3urn	ie, N	AD.
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Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be its after death. al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burn	崩	27. Manner of Death 1 Natural 5 Pend	28a. Date	h Day Year)	8b. Time of In FOUND:		y at Work?			injury occurre struck he			
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		30. Name and address of person									-		
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		850 Revelle Hig	hway				Anna	apolis					ne Arundel	
Funeral		5. Social Security Numb			e (In yrs. Ia	ast birthda	y) If Uno Mont	der 1 Year ths Days		Min.			Foreig	thplace (State or
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OX 68760, ant certificate be ex attending physician or use as the bunial.	Physician/Med	IF FEMALE: 23b. Was decedent preg	nant in the	23c. If yes, outcome 1 Live birth	me of pregi	nancy 2	Fetal death	h 3 [Ectopic pr	egnancy			Date of deliver fonth	y Day Y ear
ox 6 th cert ttendir or use a	sicia	past 12 months?	Unknown	4 Pregnant at	t time of de		Other (Sp	ecify)						
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Divisior ospital or Attend hours after death uneral Director:	Cer	4 Homicide	determined	Торос)	-									e, Mile Marker 34.2, M
Division of Vital Records, P.O. Box 68760, within 24 hospital or Attending Physician: The law requires that the death certificate be within 24 hospital or Attending Physician: The law requires that the death certificate be To the Functor! After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifier (Check only one) 2 Med	tifying Physici lical Examiner	en: To the best of m On the basis of exa	ny knowledo Imination a	ge, death o nd/or inve	occurred at th stigation, in n	he time, da ny opinion,	ite and place , death occui	, and due t red at the t	o the cause ime, date a	e(s) and and place	manner es sta e, and due to ti	ted. ne cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Pate of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 118 W. Cross St. Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Months Days Hours Director 213-16-3806 91 Yrs. 09%79%1920 Maryland Usual Residence of Decedent 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 W. Cross St. 21230 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) years Elevator Mechanic Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Edward Bland Henrietta unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Bland(daughter) 118 W. Cross St., Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 07/05/11 Owings Mills, MD 21. Signature of Funeral Service Licensee ²ĴďsephdrH°. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed andtran resulting in death) Last Due to (or as a consequence of): sician a Physician/Medical Division of Vital Records, P.O. Box 68760 phy. attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Pregnant at time of death 5 Other (specify) Month Day has been signed by the e 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Up Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 🗌 Yes 25. Was case referred to m examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pendina To the Hospital or Attendir within 24 hours after death. To the Funeral Director, At completed filled in by the fu Accident Investigation 1 🗌 Yes 2 🔲 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State. Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Fragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 30. Name person who completed cause of death (Ite and address of State 5

DHMH 17 Rev 7/2009

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			For State Registrar		yland / Depa Cer	tificate of L		F	Reg. No.	decimation (see)	-21121
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. ~	Medic Examin		4a. Facility Name (if not institution, give	,		4b. City, Town, or Location of Death			4c. County of Death		
	/ Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	Baltimo	If Under 24 Hrs.	8. Date of Birth	N/A Birth 9. Birthplace (State or Foreig.		
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	vith the 23a or st be r		10e. Street and Number 6622 Vincent Lane	<u>.</u>		10f. Zip Code	21215		10g. Citizen of	What Cour	ntry?
	items	1 1	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		ce - Americ	
9000	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ted by	1 🌃 Never Married 2 🗌 Married 3 🗌 Widowed 4 🔲 Divorced	1 Yes 2 M No If Yes, Give Year or Dates.	0	☐ Yes 2 1 No				Blac	
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212	within ygiene.		Elementary/Seconday (0-12) 10th Grade	College (1-4 or 5+)		Houseke					Express
Maryland 21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at <u>e.</u>	To Be	17. Father's Name (First, Middle, Last) Lester Evans				18. Mother's Nan	e (First, Middle, Maiden Surname) 111iams			
Mar	12 should lith and Me 27 is marl		19a. Informant's Name/Relationship (Ty India Brown – Mot				and Number or Rui Lane Balt				
Baltimore,	e 1 and t of Heal If item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Location	-	
<u>ti</u> m	permit. Page 1 a Department of I Important: If its any injury or of		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Servi → Vicens	y)	Green Mou	nt Cemet					Maryland
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مسيدية	Examiner	<u>_</u>	Sequentially list conditions,	b. Cr	Monic	500	tive	Hepa	Filis		
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JO	ath certificate be executed attending physician and for use as the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or a a c	consequence of):		9		1		
200	physici the bu	edica		d				1			
Box 68760	certific ending use as	M/m	Zob. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2		Ectopic pregnanc	01/		23d. Da	ate of deliv	ery
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ouo	er ding seth. or Afte he fune	ficat	Natural 5 Pending 2 Accident Investigation		Year) injury	M 1 □	⟨? Yes 2 □ No	28a. Describe flow injury occurred			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate by within 4b hours all er death. To the Funeral Director After this certificate has been signed by the attending physicompleted filed in by the funeral director, page 2 should be detached for use as the to complete the funeral director.	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury building, etc. (r - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Town		er or Rura	l Route Number,
	Hospi 24 hou Funer eted fill	Medical	(Check 2 Medical Exami	sician: To the best of my iner: On the basis of example se Practioner: To the be	mination and/or invest	tigation, in my opinio	on, death occurred	at the time, date ar	nd place, and di	ue to the ca	use(s) and manner stated.
_	To the within To the comp	2	29b. Signature and trill of certifier	menl	a'lmi	29c. Licens			29d. Date signe		Day, Year)
	2		30 Name and address of person who c	completed cause of dea			100		0	^ [12011
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	Sta Registr		31. Date filed (Vasth Day Year)	32. Registrar's	Signature	~			*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 4onth Jun Medical County of Death Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Baltimore owson OSDIC 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign vrs. last birthday **Funeral** □ M 2 **1** F Months Hours Min Yrs Director tarvan Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral items 2 Page 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes, Give Year or Dates Specify 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business Industry (Give kind of work done during most of working altimore life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Rac Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marsh William DOTE burn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Baito Road Pinlico Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other 4 Donation 5 Other (Specify) Task Signature of Funeral Service Lig Name and Address of Facility Fun eral Home, P 21214 North 222TW. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Complications 30 Orezup disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any leading to immedicause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ö in the past 12 months? Month Day Year be detached the Unknown 9 Unknow Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N Director: After this certificate 2 🗌 No 1 Yes ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? (2 _2 XNo Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) WOSP (C 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 \square Yes 2 🗌 No ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signed (Month, Day, Year) 201 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST TOUSONMO 31. Date filed (Mont. State 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Brooks 8:30 treaeric UNC 2011 0 /Medical 4b. City, Town, or Location of Death But fimore 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PARYLAND 6 eNeral 40SpitaL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F North Carolina 226-64-2278 -24-1955 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If lear 27 is anaked other than "natural", or Items 23a or 28a-f show amy injury or other traumatte event, the Medical Examiner must be notified at 1 ✓Yes 2 No Director Imore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2□No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DUYER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ethe 909 Balto MD Ms Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 21 Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature un ral Service Licenseg Fun W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Shirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tealth-Care Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PSis attending physician and for use as the burial-transit P.O. Box 68760€ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 3 ☐ Probably 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier packo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND GENERAL HOSPITAL ANNette NdONED, MD. mPACKO; 32. Registrar's Signature 31. Date filed (Month Day, Year) State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 20 T 38 11:24A William Bo1d John Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto. Rosedale 32 Towns Court 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number **Funeral** 1**X** M 2 □ F Months $J_{\mathbf{uly}}^{(Month, Day)}$ 29,1928Maryland Yrs. **Director** 82 220-18-8741 Usual Residence of Decedent 10a. State the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** is 23a or zo... must be notified a' Balto. Rosedale Md. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. USA 21237 32 Towns Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Pressman Printing 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Nicholas Bold Margaret Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Towns Court Rosedale, Md. 21237 item 27 Catherine Bold Spouse injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or otl 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2,2011 Parkville, Md. Moreland Service Leg Schimunek Funeral Home 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Hepatocellula Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or perlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial physiciar Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed?

1 Yes 2 No 1 Yes Division of Vital | Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 2**X** No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pendina after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title A certifier 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Franklin Square Dr. Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 30^{Day} 201°T 7:25 PM Raymond F. Bosley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTON GARDENS COLUMBIA HOWARD Social Security Numbe 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Months Davs Hours NOV 12. Director 220-07-0558 92 MARYLAND ï'918 Usual Residence of Decedent or 28a-f show 10a. State items 23a or 28a-f shoner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD HOWARD ELKRIDGE 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6213 GATEPOST WAY 21075 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) WATCH ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 RAYMOND JOSEPH BOSLEY FRANCES A. KUROWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNNE WAUGH 6213 GATEPOST WAY ELKRIDGE. MD21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) ATLNATIC GREMATION SER. 7/2/11 GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MILLER-DIPPEL FUNERAL HOME, INC.
6415 BELAIR ROAD BALTIMORE, MD 23a. Part 1 Enter the disease or complications the shock, or hear failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Hospital or Attending Physician: The law requires that the death for in the past 12 months? Pregnant at time of death 2 No the g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? page 2 certificate has 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) in 24 hours after death.

The Funeral Director: After this ce Hospital 2 No Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/200g

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ellen Braun JUNE 09:10 PM Gloria 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Sinai Hospital of Baltimore City If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 20. 22 1 □ M 2 🛣 F Months Hours 214-24-0018 84 Mary land Director Feb. Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2x No MD. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 W. Timonium Rd. 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 and Mental Hygiene. 1 Yes 2 No Specify: White 3 Widowed 4 X Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Raymond Lambert Nellie Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 700 W. Timonium Rd. Timonium, MD. 21093 Cynthia Turner/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Hilltop Service Co. 7-2-11 Towson. MD. 21. Signature of Juner | Service Licenses 22. Name and Address of Facility RUCK Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Acute Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year 5 Other (specify) Month Day Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 \ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by depression, hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown i 24 hours after death. e Funeral Director: After this certificate has been 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending work?
1 Yes 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) RES-060 June 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar

Dondlinger

Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 29, Day 2011 2:45 р м Boerner John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Brightview- Mays Chapel Ridge Timonium 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday **Funeral** 1 XM 2 🗆 F Months Min Year 1922 Septh, 24 Maryland 88 Director 215-12-9158 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits must be notified at Director Timonium MD Baltimore 1 Yes 2 No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 23a 21093 12261 Roundwood Road items permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. 9 \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: Specify: "natural", 3 Nidowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Law/State of Maryland Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dunn Edward G. Boerner Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
900 Southerly Rd., #245, Towson, MD 21204 19a. Informant's Name/Relationship (Type, Print) J. Bennett Boerner-son 20a, Method of Disposition 20b. Place of Cisposition (Name of cemetery, crematory or other place)
Hilltop Serv Corp 20c. Location - City or Town, State Date o = 0 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/1/11 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinced by the Attending Physician. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has I autopsy Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 Z No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 120515TUER

DR

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c, perfff, G917, 7/5/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day June^{Month} 201^{Year} 28 7:35 Рм Irene Scott Banerjee 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore <u>6504 Abbey View Way</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Scotland 1 □ M 2 🗓 F Months (Month, Pay, Hours Min 1930 81 Yrs 076-44-7608 Mar. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6504 Abbey View Way 21212 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Agnes Scott William Fleming Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 Abbey View Way; Baltimore, MD 21212 Chandralekha Banerjee / dtr. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Timonium, MD Dulaney variey Man Cardens 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7/1/2011 Towson, 1050 York Road Signature of Funeral Pervice Lice 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Alzheimers Demention disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

ne 29, 2011

Physician/ Medical **Examiner**

Department of Health and Men Important: If item 27 is marke any injury or other traumatic

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

notified at

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al Hygiene. Jother than "natural", or iter went, the Medical Examiner

event,

Director

Funeral

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Completed

Be

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with the Maryland

Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items

Baltimore, Maryland 21215-0036

executed and Division of Vital Records, P.O. Box 68760

for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certaincate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis

Physician/Medical Completed by Be မ Certificate: Medical

Examine

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Altery Disease 1 Yes oronary. 24a. Was an autopsy Hypertension 25. Walcase referred to medical examiner? Yes 2 No 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide injury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dav.d Weisman filed (Month, Day, Year State

29b. Signature and title of

Loch

Veisman

Raver 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009 H0059388

Baltimore MO 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G917 7/05/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month a: 200 AM Derman loby Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** A Maryland Health Care eci Known To Physicipa: BERMAN, Basil Taby Baltimore, Maryland 21215-0036 Sex 1 X M 2 D F Age (In If Under 1 Year I f Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country)
 TTA yrs. 1a 70 Funeral Hours 111971971940 VA 227-58-3541 Director Usual Residence of Decedent items 23a or 28a-f shov 10c. City, Town or Location BALTIMORE 10b. County 10d. Inside City Limits 10a, State at Director MD N/A Examiner must be notified 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2121 N. CHARLES STREET #3 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 X Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No 1 ☐ Yes 2 💢 No Specify WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) JANITOR VSP CLEAN UP SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ZIMMERMAN ဂ BERMAN RACHEL MAXWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LISA PORTERA/FRIEND 2121 N. CHARLES STREET, BALTIMORE, MD 21218 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 7/01/2011 GARRISON Crematory or other place)
VETERAN CEMETERY 1 X Burial 2 Cremation 3 Removal from State OWINGS MILLS, MD 06/29/20114 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Signs 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) 2 No g 🔲 Unknown the 9 Unknown Division of Vital Records, P.O. p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 Yes 2 No 3 Probably 4 Unknown been signature should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 2 No Other: မ 1 KInpatient 2 🗀 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Directors,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 25, 2011 7 ho completed cause of death (Item 23a) (Type, Print) YA Maryland Health Core System Horry Point M. 21902 M.D. 31. Date filed (Month: Dav. Year) State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29 Day Physician/ Charles Stephen Brown 2019 11:18PM June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Havre de Grace Harford Harford Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours 10/26/1950 Indiana **Director** 218-54-9339 60 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If ifew 27 is marked outher than "natural", or items 23a or 28a-f sho ury or orher traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Colora 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? **Funeral** 590 Love Run Rd. 21917 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter 12 0 Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles R. Brown Norma Dutrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 590 Love Run Rd. Colora, MD 21917 Donna L. Brown / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If its
any injury or of 1 Burial 2X Cremation 3 Removal from State West Chester, R.A. Ferris & Co. 7/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signatus Tarring-Cargo Funeral Home, P. 333 S. Parke St, Aberdeen, MD P.A ID 21001 zanus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIA disease or condition Medical resulting in death) **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by 'funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Yes 2**X** N the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No ပ 1 🗌 Yes 1 Inpatient 2 Renoutpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of dertifier 29d. Date signed 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD SPECTOR MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelitie Ink. Ensure All Copies Are Legible. 20a-c per fh 99177-5-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 6:55 AM 2011 Leroy Carr Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A Baltimore Union Memorial 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F 0167102 / 191933 Maryland 213-30-4933 78 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 🛚 Yes 2 🗆 No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 2101 Brookfield Ave. U.S.A. 21217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore and Mental Hyglene. is marked other than " 12th Grade College (1-4 or 5+) Museum of Art Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill the should be fill the should be filled the should be filled to a should be filled to should be filled to should be should မ Wyolia unk George A. Carr Sr. 19a. Informant's Name/Relationship (Type, Print) (sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 Brookfield Ave., Baltimore, MD 21217 Myrine E. Buford(in-law injury or other 20c_Location. City or Town, State
Baltimore,
Owings Mills, 20b. Place of Disposition (Name of one of the Carrier Period of Carrier Period Of Carrier Period of Carrier Period of Carrier Period of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Carrier Period Of Ca 20a. Method of Disposition 26 ate permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Durial 2 X Cremation 3 Removal from State 06/29/11 MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²Joseph H. Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD21217 Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset an Death Immediate Cause (Final disease or condition Ph, sician/ Myo cardial Medical resulting in death) Due to (or as a consequence of) Examiner 4 Years Chronic Kidney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Examine Due to (or as a consequence of): 4 years or Attending Physician: The law requires that the death certificate be executed (ostale Cance the attending physician and hed for use as the burial-trar burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? Day 4 Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🖵 Yes 2 🗆 No 3 🔀 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No certificate 2 K N Yes 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗍 DOA မ 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: **X** Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/22/2011 AT243 8946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University PKMY, Ballimere, MO 21218 - 2895 Hospilal Memorial Union 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death o Tay Month 07 2049 Physician/ 11:55 A M KAY COYNE SHARON Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Gilchrist Hospice Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🗆 M 2 🗓 F Pennsylvania 182-60-4252 41 **Director** Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10a. State Director 1 XYes 2 No Baltimore City MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21230 -Carroll Street U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ģ 1 X Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 - Widowed 4 - Divorced Year or Dates. 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) food service server Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smith မ Coyne, II William 1913 Seyling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1139 Carroll Street, Baltimore, MD 21230 Robert Winneberger / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 7/2/2011 Catonsville, MD 22. Name and Address of Facility The Johnson Funeral Home, P.A. 21. Signature of Funeral Service Licensee MOO217 8521 Loch Raven Blvd.; Towson, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph, sician/ Cervi 4270 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execute sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🕅 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes] Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: 27. Manner of Death injury Natural
Accident
Suicide
Homicide 5 Pending 1 🗆 Yes 2 🗆 No Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 17 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatu and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAAA N T CARNUES MD CTOL N, Clurices State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ^{Day} 2011 Physician/ June 27 1:50 PM M Carmen Chimera Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville Rockville Nursing Home If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Iar 4, 1934 Months Days Hours New York 1 🔀 M 2 🗆 F Mar 77 **Director** <u> 289-28-1112</u> Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No N. Potomac MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20878 10 Quince Mill Court death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No δ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 lith and Mental Hygiene.
7 Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Hewlett Packard sales engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jenny Zampelli Russell Chimera 3b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $10~{
m Quince}~{
m Mil}~{
m Lourt}~{
m N.}~{
m Potomac,}~{
m MD}~{
m 20878}$ 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 Is any injury or other trau David Chimera/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) gnal To of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician respiratory failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami hypertensive heart disease burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical pneumonia spital or Attending Physician; The law requires that the death certificate be ours after death.

leral Director; After this certificate has been signed by the attending physicis filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 L Yes 2 L g D Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 2 🗹 No ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of swowns June 27, 2011 D 0047330 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Thomas

V. Date filed (Month, Day, Year,

05

Joseph MD 5020 Edmonston Drive

32. Registrar's Signature

Suite 207 Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 29, Day 2011 Year Physician/ 7:50 pm Gloria Eleanor Cieri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore n/a Symphony Manor S. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days April 2. Min 219-22-5713 1 🗆 M 2 😾 F 83 Marvland Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Baltimore n/a 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral 21210 U.S.A. 4301 Roland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 0 ģ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 XNo Specify: White Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pension Auditor IRS Agent Department of Health and Mental Hygies Important; If item 27 is marked other! any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Badolato Malatesta Grace Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13910 Glen High Rd., Baldwin, MD 21013 Domenic L. Cieri, Jr.,-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment 7/7/11 Timonium, MD Dulaney Valley 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ement 200 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease or imjury use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ò Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by is certificate has been signe director, page 2 should be o 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other (Specify)} \) ASSISTED. 2 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hd To the Fund completed it Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 58 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year) State

MARIES 32. Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Lee 201 50 Dorn 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Franklin Square
Social Security Number 16 Kosedal Hospita Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 8. Date of Birth 1 □ M 2 😿 F Months Hours Min. Director Month, Day, Year, 9/7/1957 218-72-1002 53 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3620 Dahlia Lane 21220 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 Mo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Noivorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Joseph Dorn Mary Dorothy Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Joseph Dorn (Father Middle River, Maryland 21220 3632 Bay Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 7/3/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death (Tiysician) Due to (or as a con-equence of): disease or condition Medical resulting in death) Examiner minant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cirrhosis attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 s autopsy performe death? 2 X No Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ည 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No after death

Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours area.

To the Funeral Direc. 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on 29b. Signati and title of 30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 9000 Franklin Square Drive,

inskaya MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 600 **Physician** Josephine M. Dymond 60 28 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rosedale Baltimore FRANKLIN Square Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛱 F Director 217-60-1136 Sept 19, 1946 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exercitivat must be notified at Director MD 1 ☐ Yes 2√2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 68 Transverse Avenue 21220 Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 0 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Rosengrant Mildred Dialey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a important: If Item 27 Is any Injury or other training. Joseph Dymond/spouse 68 Transverse Avenue Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wirector Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, scheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HearT Congestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STage End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): physician at the burial P.O. Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 Tyes 2 To 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 No 2 - No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide

Division of Vital Records, To the Hospital or Attending Physician: after within 24 hours a

To the Funeral I

completely filled

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Dymond

State

DHMH 17 Rev 1/2001

Medical

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

4000 FRANKLIN SQUARE DR Balto md 21237 KottaraThIL DRJOhn 32. Registrar's Signature

HoHarti (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D69198

JUNE, 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ lon Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Randallstown Baltimore Season's Hospice at Northwest Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Months Hours Min. 88 214-16-3477 Mary Land Director Usual Residence of Decedent show 10a. State 10b. County the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 21211 10g. Citizen of What Country? ò must be i Funeral 1413 Roland Heights Avenue ural", or items ? Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural" Completed 3 XWidowed 4 Divorced it of Health and Mental Hygiene.

If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Armco Steel Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert William Easton Pearl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1413 Roland Heights Avenue, Baltimore, Maryland 21211 Arlon Sitterly Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/2/2011 Lorraine Park Cemetery Woodlawn, Maryland Name and Address of Eacility Burgee Henss-Seitz Funeral 3631 Falls Road, Baltimore, 21. Signature of Funeral Home, Inc. altimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Stag disease or condition resulting in death) Medical Due to (or as a conseque e of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or ilinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant 9 Unknown 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Inpatient Hospice Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral directors. After this 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

31. Date filed (*Month, Day,* Year)

JUL 0 5 2011

MSRajapahum.D

N.S. Rajupakse, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

Smith AV

D0057465

5-203

Baltimore MD

29d. Date signed (Month, Day, Year)

6/29/11

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year George Physician /Medical 201 june 22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 ▼ M 2 □ F Months Days Hours 220-24-2844 82 June 10, 1929 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 21231 614 S. Patterson Park Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2💢 No Specify: þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If item 27 is marked other than home improvements house painter unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Zebelean Nicholas Everd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Ridgewood Avenue Felton, PA !&#@@ 16 Ridgewood Avenue Felton, Harry King/nephew Baltimore, permit. Pages 1 ar
Department of Hea
Important: If item 2
any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 NOther (Specify) in state License 21. Signature of Funeral Service State Anatomy Board 655 W. Baltimore Street Director un Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner 0 Idium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760, Physician/Medical attending IF FEMALE: nse If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year page 2 should be detached for Pregnant at time of death 5 Other (specify) 2 🗌 No P.0. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe Yes 2 1 Yes 2 No certificate Division of Vital 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 4
Nursing Home 1 Inpatient 3 🗆 DOA 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) ၉ this filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation (Month, Day Year) Attending 1 Natural 1 Yes 2 No death. e Hospital or Attendi n 24 hours after death. e Funeral Director: A 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 5 2011

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 June 18, 3:30 AM M Stanley A. Eagle Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac HCR Manor Care 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Jan 21, 1 M 2 - F New York Director 87 L09-16-1646 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Potomac MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 5 10e Street and Number ms 23a or must be n Funeral 20854 USA 10714 Potomac Tennis Lane Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. o. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced 41-45 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kate Abrahams Philip Eagle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 Clarendon Road #3 Bethesda, MD 20814 19a. Informant's Name/Relationship (Type, Print) 7105 Clarendon Road #3 Bethesda, MD Susan Eagle/spouse Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ▼ Donation 5 ☐ Other (Specify) Signatur of Emeral Service Licensee ^{22. Name and Address of Facility} Board 655 W. Baltimore Street MD 21201 23a. Part 1. Exter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aspiration pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last dmentia and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal cell carcinoma, nephrectomy 1999 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No has 24 hours after death. Funeral Director: After this certificate 25. Was case referred to medica director. 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 🗌 No ြု 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 201 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller MD 8218 Wisconsin Ave #305 Bethesda, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1054 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EGOW M berland 1/cnc 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 **№** 2 □ F Maryland 2/28 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be nutflied at 1 ☐ Yes 2 No Director **Allegany** Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 12808 Irene Drive NE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 No white Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental HImportant: If Item 27 is marked oth any Injury or other traumatic event Be Cecil William Fresh Mary Martha Laurie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Fresh/spouse 12808 Irene Drive NE Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Lunary Service Ronal of 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) month **Physician** , /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending physi If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Ye ar 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person

Industrial Blod Cumberland

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #27 Per FH G917 7/05/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1a:45au Physician/ 06 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** N/A Joseph Richie Hospice Baltimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖔 F Dec 4, Day 1966 Hours Min. Mary Yand 44 217-82-2498 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 ¥ Yes 2 □ No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 21225 10e. Street and Number 1001 Renick Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give black 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ô retail sales clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Betty Walker Hayward Gamble Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3611 Kenyon Ave; Baltimore, Maryland 21213 Kemma Jones - sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Wother (Specify) in State 07/01/11 Baltimore, Woodlawn Cem. 22. Name and Address of Facility of Trull on Ave 21217 (55. W. Baltimore St. Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Gagaintany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): for use as the burial-transit signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown **To the Funeral Director:** After this certificate has been signe completed filled in by the funeral director, page 2 should be a 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed Yes 21 death? ピとと 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medical examiner?
1 \(\subseteq \text{Yes} \) Other: Hospice 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ပ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 🗌 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in supplier. Medical 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H006426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Under Av Bust vio 21201 31. Date filed (Month, Day, Year) State Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c &22 Per FH G917 //11/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1.06 SUNE 2011 George L. Guthrie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balhing/C
If Under 1 Year | If Under 24 Hrs. | Hours | Min. Hospi hul 5+. A 500)
5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1**X** M 2□ F Months 218-42-1298 Apr 24, 1946 Maryland **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3648 Washington Blvd #126 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) mechanic bookbindery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Leroy Guthrie Irma Wellsworth မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2620 Pleasant Hill Rd Hanover, PA 17331 Tammy Clevenger/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4□Donation SEOther (Specify) <u>in state</u> 7/11/2011 Atlantic Crematory Glen Burnie,MD 22. Name and Address of Facility Simplicity Cremation Funeral T.A. State Anatomy Board 522 W. Baltimore Street 21. Sign ture Fruneral Service Licensee Ronal S Waste Director 21201 7090 Ridge RD. Hanover, MD Baltimore, MD Approxima 1076 Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 31 days Ischenic Bond disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Reptired Abdaminel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence or): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Perphal Vascular Direspe Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00066251 JUNE 28, 2011 MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE, BALTMORE 900 MD CROSS, WIRT CATON 21229 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ Tune George ores Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Year) Dec 8, 1933 If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Maryland Min. 1 □ M 2 😾 F 77 218-28-8254 Dec Director Usual Residence of Decedent per it. Page 1 and 2 should ce filed within 72 hours after death with the Maryland De; artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2X No Pasadena Anne Arundel 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 21122 USA 329 Queen Anne Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married CTROYGE, DOLOYES
Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) osn home housewife 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ida May Siegert Albert Theodore Reitterer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
329 Queen Anne Road Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Henry George/spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature 1 merel Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronald 23a. Part 1. Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Jexsis disease or condition resulting in death) Medical Examiner TION Sequentially list conditions. Examine Due to (or as a cons uence of If any Lading to immedia cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the dea h cert ficate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the a lending physician and ed by the a ending physician and detached frruse as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? i signed b Id be deta þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed nis certificate has been si I director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tyes Yes 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c, License number 29b, Signatu

State Registrar who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) N AUS June Physician/ Gleicher 2011 ena Medical 4c. County of Death HOWARD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** COLUMBIA 5400 VANTAGE POINT ROAD APT. 1104 If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs. last birthday) 93 yrs 8. Date of Birth 5. Social Security Numbe 072-14-4395 Funeral 0476471918 1 🗆 M 2 🛛 F Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location COLUMBIA er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director HOWARD MD 1 ☐ Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 21044 0e. Street and Number USA 5400 VANTAGE POINT ROAD APT. 1104 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname)
ALDORODY Be 17. Father's Name (First, Middle, Last) RACHEL PASSY ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11660 MASTERS RUN, ELLICOTT CITY, MD 21042 DENNIS GLEICHER/SON IN LAW Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place)
COLUMBIA MEMORIAL PK. 07/01/2011 COLUMBIA, MD 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 22. Name and Address of Facility SOL 21. Signature Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) CAzoio Viscular discose **Examiner** thuo scleratio Superitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine HYPERTENSIO burial-transit and resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy tor: After this certificate has the funeral director, page 2 s performed death? 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 - Pending Natural 2 Accident
3 Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in by City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce Jue 29, 2011 Columbia, Maybell 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEL MUKOUT State 0 5 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 28 20T1 7:45 a M **EDITH** LUE HOPKINS Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 10490 Sugarberry St. Waldorf Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Sep 1, Day, Year 18 1 M 2 X F Hours Min. 217-22-8879 92 VΑ Director Usual Residence of Decedent or 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the Maryland front of Health and Mental Hyglene. It ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10490 Sugarberry St. USA 20603 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No Specify: Specify: 3 X Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas P. Jones Mary Booker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1201 Firth of Lorne Circle Mary Hopkins-Navies/daughter Fort Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7-5-2011 King Memorial Park Baltimore, MD Signa Funeral Service License 22 Name and Address of Facility one 4300 Wabash Ave. Baltimore, MD 21215 the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death 23a Pa 1 Enter the disease or complications that cause s ock, or heart failure. List only one cause on each line ediate Cause (Final Curho815 Pnysician/ months Medical Due to (or as a const quence of): resulting in death) **Examiner** YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cardiovascular disease Cause (Disease or linjury that initiated events attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ¥ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementia, ADVANCED 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕱 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

4 Homicide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at the time,	date and place, and due to the cause(s) and manner stat
29b. Signature and title of certifier July	29c. License number P00 28 54 4	29d. Date signed (Month, Day, Year) Guly 02, 2011
30 Name and address of person wito completed cause of death (Item 23a) (Type, Print)	treet Howywood, r	MD. 20636
31. Date filed (Month, Day, Year) 5 2011 32. Fight are Signature 6. Sau	W	

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Harris		1- For State Registrar	State of Maryland		artment of rtificate of		d Mental F		20 l	2 14
Physic Medical Exam		Decedent's Name (First, James Edward			-			2. Date of Dea Month June 23, 2	Day Year	3. Time of Death 1642 hrs
			stitution, give street and number	er)	1	4b. City, Town, or Baltimore	Location of Dea		4c. County of Dea	
Funeral		5. Social Security Number		Age (In yrs. I	ast birthday)	If Under 1 Yea			rth(MM/DD/YYYY) 9. B	irthplace (State or
Director		218-44-2996	1 M 2 F	65	Yrs	Months Days	s Hours Mi	Oct.	1, 1945 Fore	country Virginia
any		Usual Residence of Deceder 10a. State 10b. Co		10c. City,	Town or Locati	on				10d. Inside City Limits
Aaryland 28a-f show	tor	MD 10e. Street and Number	N/A	Balt	imore	10f. Zip Code			10g. Citizen of What Co	1 Yes 2 No
the Mar a or 28s	Director	415 N. Montf	ford Avenue				1224		USA	
ath with tems 23 st be no	Funeral	11. Marital Status	Married Armed Force	s?		I s Decedent of His es, specify Cuban				erican Indian, Black,
ifter dez 11", or i	by Fu	3 Widowed 4	Divorced If Yes, Give Year or Dates:	2 📝 No	1	Yes 2 No	specify:		Specify: Bla	ck
hours a		15. Decedent's Education Elementary/Secondary (0	(Specify only highest grade c			t's Usual Occupat ost of working life.			16b. Kind of Business	/Industry
036 vithin 7, ene. cr than Medical	Completed	10th Grade		,			ntrolle		1	Bakery
THOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiens and anti-If item 27 is marked other than "natural", or items 23a, or 23a-f she mait. If item 27 is marked other than "natural", or items 23a, or 23a-f she not other traumatic event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, M Stump Beryl	iddle, Last)				^{18.Mother's Nam} Eva Har		Maiden Surname)	
D 2121; should be fill and Mental It is marked	To E	19a. Informant's Name/Rela				Address (Stree	t and Number or	Rural Route Nur	mber, City or Town, State	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition	Robinson — Dau	20b. F		tion (Name of cen		Date	ood, Maryla 20c. Location - City o	
Baltimore, Dermit. Pages I as Department of Hes Important: If ite		4 Donation 5 Oth		Olaio	en Moun	it Cemete		5/2011	Baltimore	, Maryland
Balti permit. Departu Import injury		21. Signature of Funeral Se	rvice Licensee			ame and Address	u		ris Funeral H yland 21206	ome 7
Physician		23a. Part I. Enter the diseas failure. List only one c	se, or complications that cause cause on each line.	ed the death.	Do not enter th	e mode of dying,	such as cardiac	or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final dis or condition resulting in dea				se				Death
	-	Sequentially list conditions, if any, leading to immediate		nsequence of	r):					
	Examiner	(Disease or injury that initial events resulting in death)	ause c.							
and and transit	al Ex	,	d	<u> </u>						
60, tte be exe hysician e	Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcome	ome of prear	nancy				23d. Date of delive	
Box 6876 death certificate the attending phy	sian/	23b. Was decedent pregnan past 12 months?	1 Live birth		2 Fet	al death 3	Ectopic pregn	ancy	Month	Day Year
Box he death the atte	Physician/N	1 Yes 2 No 9	Unknown 9 Unknown		3 Off	ner (Specify)		Loo. Bill		
P.O.	ρ	Part II. Other significant co Chronic Alcohol A		ath but not re	sulting in the ui	nderlying cause g	iven in Part I.		obacco use contribute to s 2 No 3 Pro	
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed ther this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transi	Completed							24a. Was autop	osy prior to	utopsy findings available completion of cause of
tal Rec		25. Was case referred to me				00 Pleas	- CD	1 Yes	rmed? death? 2 No 1 Y	
Vital Nysician this cert	To Be	examiner?	Hospital:	tient 2	ER/Outpatient		of Death (Check Other: Nursi		Residence 6 Othe	er: Scene
n of Iding Pl h. : After e funeral		27. Manner of Death 1 ✓ Natural 5	28a. Date of Ir (Month, Day Pending	njury v,Year)	28b. Time of In		y at Work? es 2 No	28d. Describe I	how injury occurred	
Division tal or Attendi rs after death. al Director: A	Certification:	2 Accident 3 Suicide 6	Investigation Could not be 28e. Place of	Injury - At ho	ome, farm, stree	t, factory, office bu		28f. Location (S or Town, S		ural Route Number, City
Divi fospital or hours afte uneral Dir		29a. Certifier	determined (Specify) ng Physician: To the best of	my knowledo	ne death occur	ed at the time da	te and place and			ted
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one) 2 Medicai	Examiner:On the basis of ex and manner states	camination ar	nd/or investigati	on, in my opinion,	death occurred	at the time, date	and place, and due to t	he cause(s)
	Σ	29b. Signature and tiffe of co	ertifier	1	11	29c. License			29d. Date signed (Mo	onth, Day, Year)
4			erson who completed cause of			+		<u>-</u>		<u> </u>
	ate	Russell Alexander 31. Date filed (Month, Day, Y		ical Exam		V. Baltimore	Street, Baltir	nore, MD 21	223	
Regis			hama A	back	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9.05am William Hammond Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Joseph Ritchey Hospice N/A 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months 1937Marvland 73 Director 20-36-6482 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director Baltimore Maryland N/A 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21212 USA Avenue Richwood Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married 2 No Specify Black Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Private Industry Elementary/Seconday (0-12) College (1-4 or 5+) Contractor 8th grade 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Hammond 17. Father's Name (First, Middle, Last) Should be file permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev John Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 521 Richwood Avenue Baltimore, Maryland Helen Scott/ Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Funeral Service License Baltimore, MD 21215 23a. P. . Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest allock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.Ó. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ammond Completed by emplysema 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate homelafted filled in by the funeral director, page completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence to colco. 1 Inpatient 2 ER/Outpatient 3 DOA ည Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accider 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 2011 (Month, Day, Year) State Registrar

9:05 AM

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JULY Day 20^{Year}1 Hevelman 8:40 Α Charles Abbott Medical 4a. Facility Name (if not institution, give street and number)
ST JOSEPH MEDICAL 4b City Town On Location of Death Examiner 4c. COUNTY OF THORE CENTER Social Security Number 6. Sex 1 X M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Min $J_{\mathbf{ulv}}^{(Month, Day, Year)}$ 10, 1925 Massachusetts Yrs. **Director** 726-07-0017 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at with the Maryland Director 28a-f 1 🗌 Yes 2 🎗 No MD Baltimore Timonium r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2317 Spring Lake Drive death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 5 ģ 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No Specify 3 🕅 Widowed 4 □ Divorced Specify: "natural" Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) American Sugar Co. 04 Electrical Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked ot traumatic ever 2 The 1ma Estelle Nickerson G. Heyelman Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health art: If item 27 is 7231 Bend Lane, Wrightsville, PA <u>Keith A. Hassler/Nephew</u> 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 7/12/11 Department o Important: If any injury or Donation 5 Other (Specify) Paul's Wolf's Cemetery York Co., PA 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 pure of Funeral Service Licer Bryan Welchary 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real failure. List only one cause on each line. Approximate Interval Retween Immediate Couse Final MULTI ORGAN FAILURE 20 hours Ph_sician/ disease or condition resulting in path Medical Examiner Due to (or as a consequence of) 20 hours SHOCK Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying 20 hours CARDIAC ARREST that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending phys for use as the I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEMORRHAGE SPONTANEOUS RIGHT ABDOMINAL WALL 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N this certificate 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at al or Attending P s after death. I Director; After 1 Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

DHMH 17 Rev 7/2009

State

Registrar

only one) 29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed LINDA BARR, M.D.

05

OSLER

my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DRIVE TOWSON, MD 21204

D35453

29d. Date sig

ed (Mbnth, Day, Year)

Quitifying Narse Practioner: To the

mpleted cause of dear 7601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nocti Nocti WRENCE 2011 305 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandarin Hospice House Harwood <u> Anne Arundel</u> 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 D F Min Nov 16, 1943 Maryland Director 67 216-42-5984 Usual Residence of Decedent show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2X No Harford Abingdon MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 2835 Browning Court 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗓 No Specify. white Specify: 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lawrence Richard Harmel Deloros Caroline Hoffmeister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Whitney Sackett/daughter 24 Millhaven Court Edgewater, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signal In Ligureral Service Licentia Ronal d S State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) A Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ဂ္ 1 🗌 Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) Signature and title of cer cause of death (Item 23a) (Type, PT) EFENSE HWY ANNAPOLIS MOZIYO ame and address of perso Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

			For State Registrar	Oldio of Mic		ertificate of			eg. No.	3 1	
	Physic	ian	1. Decedent's Name (First, Middle, La	st)				2. Date of Dear Month	Day	Year	3. Time of Death
	/Medi		Iris MaryLou Ha					June	21 20	011	3:00 P M
	Exami	ner	4a. Facility Name (If not institution, giv				r Location of Death	1	4c. County o	of Death Omic	
**	Funeral		21532 Wetipquin 5. Social Security Number 6. S		(In yrs. last birthda	Tyask:		8. Date of Birth (Month, Day			lace (State or Foreign
	Funeral Director		222-28-8636	I□M 21 F	65 Yrs.	Months Days	Hours Min.	Nov 16,	1945	Dela	ware
	and sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	_ocation				1	0d. Inside City Limits
	Mary f sho	ğ	MD Wico	mico	T.	yaskin					1 □ Yes 2X□ No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W		itry?
	23a c	la L	21532 Wetipquin	Road			21865			USA	
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ∐Yes 2X N	ver in U.S. 13	 Was Decedent of H If Yes, specify Cub 	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		· Americ	an Indian, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventher rount to notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 24 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🏋 No	Specify:		Specify:	wh	ite
15-("natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done . DO NOT use retire	oation during most of wor	king	16b. Kind of Bus	siness/Ind	dustry
12	and 2 should be filed within 7 salth and Mental Hygiene. n 27 is marked other than "rer traumatic event, the Med	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	cosmotolo			cosmoto	logv	
þ	il Hyg other vent,	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle,			
/lar	uld be Vienta Irked Itic ev	2 E	Ira Allan Garb	utt			Mary	Rosella	Hallis	ey	
Maryland	and I is ma		19a. Informant's Name/Relationship (iling Address (Street			r, City or Town,	State, Zip	Code)
é, ≥	1 and 2 Health em 27		James Doughty/hu	sband		532 Wetipo	quin Road			2186	
more	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4X Donation 5 ☐ Other (Specie		cemetery, ci	position (Name of ematory or other pla	ce)	Date	20c. Location - (City or 10	wn, State
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer		ctor	22. Name and Addre tate Anat	omy Board		Baltimo	re S	treet
			23a. Part 1. Let the disease, com shock, or let fail le. List only	plications that caused	the death. Do not e	saltimore, nter the mode of dyi	MD 2120 ng, such as cardiac		rest,		Approximate Interval Between
-	Physician		Immediate Cause (Final	one cause on such lin	e.	Cime	1				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	Wille	C. N.				0 000
	Examiner		Sequentially list conditions	b.	*						All .
	ed sit	iner	Sequentially list conditions, if any, leading to him educe cause. Enter Underlying Cause (Disease or injury that initiated events	Dusi to (or as o	do eanimpeanos of:						
_	xecute and I-trans	Examiner	that initiated events resulting in death) Last	c	a consequence of):						
68760,	rtificate be executed ng physician and as the burial-transit			d							
99	rtifica ng ph as th	Medical	IF FEMALE:						10.00		
Box	eath cer attendir for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death	B ☐ Ectopic pregnan	су		23d. Date Mor	e of deliventh	ery Day Year
0	Attending Physician: The law requires that the death ce r death. critosath. ector: After this certificate has been signed by the attendi by the funeral director, page 2 should be detached for use	Physician/	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	i ☐ Other (specify) _					24)
Ф.	s that ned b	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contr	ribute to t	he cause of death?
rds	w requires been sign should be							1 □ Y	es 2 ⊠ o	3 ☐ Prol	oably 4 ☐ Unknown
Vital Records,	law re as ber 2 sho	Completed						24a. Was a	an 24b. V	Vere auto	ppsy findings available impletion of cause of
<u> </u>	The cate h	E 0						perfor	med2 d	leath?	2 □No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Heavitali		lou-		ath (Check only or	ne)		
of	Physical this call directions	은:	1 ☐ Yes 2 No 27. Manper of Death	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpat	ent 3 DOA	ner: 4 Nursing H		ence 6 Othe		fy)
on	ding Ph h. After th funeral	ţi	H Natural 5 Pending	(Month, Day		Wo	rk?]Yes 2∐No	200, Describe II	ow anjury occurre	eu	
Division	Attendi death. ctor: /	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, farm,		100 100	28f. Location (S	treet and Number	er or Run	al Route Number,
Ö	talor, rs after al Dire	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)			City or Tow	n, State)		
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by tt	edical	29a. Certifier (Check only one)	hysician: To the best ominer: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and madate and place, a	anner as a	stated. o the cause(s)
	To the within To the comp	Me	29b. Signature and hite of certifier			29c. Licens			29d. Date signed		
			1 Van	20		10	2050	7	0/23	5/21	0)1
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print)	2050. 1088021	C+ 5	HINCH	31121	w mD
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	4.1	NURVI		110121	7 41 00	7
- 2;	Regist		JUL 0 5 201	1 Seven	r's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CENTER RAVEN LOCH COMMUNIT UV VG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Numbe 6. Sex Age (In yrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21229 15+ items 23a 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ "natural", or 1 Never Married 2 Married within 72 hours after Yes 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Black 3 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DP NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementari ec∳nday (0-12) College (1-4 or 5+) pars Be and 2 should be filed Health and Mental Hyo 17. Father's Name (First, Middle, Last) Mother's Name (First., Middle, Maiden Surname) ပ nformant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Funeral er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Eper the disease, or complications that caused shock or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician if or use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the at Id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Records, The law requires cate has been sig page 2 should b Completed 24a. Was an autopsy performed? Yes 2 N After this certificate funeral director, pag To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital 2 KNo ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Yes 2 No Natural Accident 5 Pendina within 24 hours after death. To the Funeral Director: A completed filled in by the fu М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer

23d. Date of delivery Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 28f. Location (Street and Number or Rural Route Number, LOCH RAVEN BLVD

3. Time of Death

rginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 ☐ No

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

me

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ mes LD Medical County of Death 4a. Facility Name (i institution, give street and number) 4b City, Town, or Location of Death **Examiner** Im MILLIM 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 67 Months Hours Min MARYLANO 1 M 2 **Director** Residence of Decedent items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** SAItIMORE 1 X Yes 2 No 10g. Citizen of What Country? of 304 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 6 þ 1 Never Married 2 Married にしば サームの11 altimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: AMERICAN "natural" Completed 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee, Elementary/Seconday (0-12) Page 1 and 2 should be filed within College (1-4 or 5+) Greeter Be 17. Father's Name (First, Migdle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည atham AthAm AMES 19a. Informant's Name/Relationship (Type, Pript) Rural Route Number, City or Town, State, Zip Code) MARYLAND 2644 Smith daughter ROL 20b. Place of Disposition (Name of 20c. Location - City or Town, State Method of Disposition Date cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State BAHLMORE Notional SAHLMORE MARY LAND 4 ☐ Donation 5 ☐ Other (Specify) 21229 re of Funeral Service Licenses BAHIMORE MARGIANA FRANKlin art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or their failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Certificate: To 1 Yes ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗆 4 Nursing Home 5 Residence Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of De th 28b. Time of 28c. Injury at work?
1
Yes 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Accident injury 5 Pending 2 No Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar Name and add

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who completed cause of death (Item 23a) (Type, Print)

RN

2. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ Miller Johnson 01 Day Frank 20 1 1 5:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford 4b. City. Town, or Location of Death Examiner Aberdeen 37 Green Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Yea 11 V 14, 1**X** M 2 □ F Months Days Hours Min. 92 Virginia 215-16-0919 July Director 1918 Usual Residence of Decedent i Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State with the Maryland Director Aberdeen MD Harford 1 X Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21001 Funeral 37 Green Avenue within 72 hours after death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 Specify:White 1 ☐ Yes 2X No Specify: 3XWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Petroleum Fuel Station Owner 8 0 Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ of Health and Menta f item 27 is marked r other traumatic ev James Walter Johnson Lilly Brown Sult 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1121 Old Philadelphia Rd, Lot 53, Aberdeen, MD, 21001 19a. Informant's Name/Relationship (Type, Print) Gwen A. Burris / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Mem. Gdns. 7/6/2011 Bel Air ^{22. Name, and Address of Facility} Funeral Home Tarring-Cargo Funeral Home 333 S. Parke St, Aberdeen, Home, MD of Fyneral ·A 21001 23a. Part + Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final senal failur chronic Physician nears disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** nears NUNTASULIA Dependant Diabetes nellity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo After this certificate has funeral director, page 2 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1X Natural 5 Pending Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one

State Registrar 31. Date filed (Month, Day, Year) JUL 0 5 201

29b. Signature and title of certifi-

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Prashart Shukla MP 15 S. Parke St. #4W Aberdeen MD 2100 |

29c. License number

D00048050

29d. Date signed (Month, Day, Year)

7/1/11

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death Time of Death **Physician** 09 PM 2011 Kerr Jarrion S-121 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Country) Mar 2000 213-59-0514 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 28a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Director altimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 301 Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) Von 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ပ onne ato Va ebose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tranonce. Balto AVE. MD 1ddison 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the clisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (o' as a consequence of): disease or condition resulting in death) /Medical Examiner District of the a sessequence of). Sequentially list conditions, they bedrig to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 XYes 2 □ No 2 K ER/Outpatient 3 □ DOA 5 Residence ပ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury s after death. 1 🗌 Yes 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 24 201 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 MULTE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 02:50 AM NISSI KOUKA TUNE 21 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17, 2011 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. Maryland 1 □ M 2 🛱 F **Director** infant Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Movical Examiner must be notified at 1√Yes 2□No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 USA 616 Walker Avenue death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kouka ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 S. Greene Street Baltimore, MD University of MD Medical Center 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□Other (Specify) in state 21. Signatur Funeral Service Licensee Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Caus (Final WITH MULTIPLE CONGENITAL ANOMALIES Physician RISOMY 9 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGENITAL HEART DISEASE OMPLEX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🔀 No 1 ☐Yes 2 🗖 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760, P.O. Division of Vital Records, ours after death.

neral Director: A
filled in by the fo To the Hospital within 24 hours a To the Funeral Completely filled Hospital

State

Medical

Registrar

(Check only one)

29b. Signature and title of certifier

Omeniva

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE STREET, BALTIMORE MENIRU, 22

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 72093 29d. Date signed (Month, Day, Year)

21: 2011

JUNE

MD

21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 01 8:30 AM JULY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 8419 ROCKY MOUNT ROAD BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-92-8774 Days Hours Min 037057 1927 24 Director MD Usual Residence of Decedent 28a-f show 10a. State 10b, County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 23a 8419 ROCKY MOUNT ROAD 21237 USA items Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN UNKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည IRVING KROHN ANNA NOSOLOWILEH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RON CHRISTIAN/CARE GIVER 7215 YORK ROAD, BALTIMORE, other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) SHAAREI TFILOH CEM 07/01/2011 BALTIMORE, MD 21. Signature/pf Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Dile to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical death certificate be P.O. Box 68760 the use as yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 ☐ Yes ≥ L g ☐ Unknown the g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ arrettis Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law has page 2 performed OSPIPATION this certificate 2 🗌 No 0 1 Yes Yes 25. Was case referred to med al examiner? 26. Place of Death (Check only one) Be GroupHome Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 29b. Signat re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Baltimore MD 21234 31. Date filed (Month, Day, Year) . Registrar's Sig State 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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19	Funeral Director	Г	5. Social Security Number 6. Sec. 216 - 77 - 3815	M 2 \square F 7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		ountry Korea												
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21215-0036	ithin 72 hour iene. r than "natu the Medical		15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work		16b. Kind of Business													
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	and deal em :		19a, Informant's Name/Relationship (Type 19a, Informant's Name/Relationship (Type 20a, Method of Disposition		19b. Mailing Address (Street 5/62 Du	tham t	· ~		MD 21044												
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		1 ☐ Burial 2 Commation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	emoval from State A	netery, crematory or other pla	ce) 7	1/204 swell	Hanow	er, MD												
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. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be the A fours after death. The Euheral Director: After this certificate has been signed by the attending physic mpleted filled in by the funeral director, page 2 should be detached for use as the bit is a sound that the funeral director is a sound be detached for the bit is a sound be detached for the bit is a sound be detached for the bit is a sound be detached for the bit is a sound be detached for the bit is a sound between the bit is a sound b					þ	by	þ	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnand 1 Live Birth 2 Fetal of 4 Pregnant at time of der 9 Unknown	death 3 🔲 Ectopic pregnan	су		23d. Date of de Month	elivery Day Year
Division of Vital Records, P.O.	fuires that the signed by all the detact								Part II. Other significant conditions cont		ting in the underlying cause gi	ven in Part I.		obacco use contribute t	o the cause of death?						
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Divisio	to the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)			28f. Location (S City or Tow	Street and Number or Ri vn, State)	ural Route Number,												
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	9		30. Name and address of person who con				Catous		21228												
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	1. parks																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ida I. Lopez June 2011 3:47 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Center Timonium Baltimore Co. 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 29,1928 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Months Hours Min. 212-23-5338 **Director** Yrs 82 Maryland Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Baltimore Dunda1k ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 1608 Oakway Drive 21222 United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2X Married e filed within 72 hours after ntal Hygiene. ed other than "natural", o Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o 2 Louis Menin Theresa Columbera 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mr. Daniel D. Lopez, 1608 Oakway Drive Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 Donation 5 Other (Specify) Gazrison Forest V.A. Cem. 6/30/2011 Owings Mills, MD 21. Sig ature Duda-Kuck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ **z** 9 ☐ Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 "Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X** No 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA \square Nursing Home 5 \square Residence 6 f X Other (Specify) f HOSPICE27. Manner of Deatl 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) X Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours after the Funeral Dire mpleted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Mainth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMH 17 Rev 7/2009

State Registrar

5

JACKIE JONES, CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

11-04791 Julian Mckay Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 21160

ian ivickay		1- For State Of Maryland / Department Certificate			2011	21100
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death		3. Time of Death
edical Exami		Julian McKay		June 27, 20		1342 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death	Λ
		St. Agnes Hospital 5. Social Security Number 16. Sex 17. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24	drs 8 Date of Birth	MM/DD/YYYY) 9. Birti	hplace (State or
Funeral Director		クつ	Months Days Hours M	Ain. 0621	Foreign	n intry) MD
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nd show	5	MD N/A Balt	imore			1 Yes 2 No
te Maryland or 28a-f show any fied at once.	Director	10e. Street and Number Ant	10f. Zip Code	10g	. Citizen of What Coun	try?
h the 3 3a or		6 North Woodington Road "GO	21229		USA	
th with	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
er dea		Never married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: 3	ack
urs aft tural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kind		6b. Kind of Business/Ir	ndustry
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life, DO NOT use i	retired)	Walr	navt
within ene.	Completed	12thgrade N/A	Stocker	ma (First Middle Ma	•	71000
MD 21215-0036 2 should effice whim 72 hours after death with the Maryland h and Mould effice within 72 hours after death with the Maryland Ty is marked other than "natural", or items 23a or 28a-faha matie event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	18.Mother's Na	me (First, Middle, Ma		
212 uld be Menta marke	o Be	19a. Informant's Name/Relationship (T pe, Print)	iling Address (Street and Number	or Rural Route Number	er, City or Town, State,	Zip Code) 21026
MD d 2 sho lith and n 27 is		Kevin McKay / Father 12	Valley Lake Pl	ace Apt.	K Lockeys	lile MD
re, land land land land land land land land			position (Name of cemetery, r other place)	1 1.	20c. Location - City or	Town, State
Pages nent of		4 Donation 5 Other Specify: Arbutus	3 Memorial 0	F109/2011	Baltimor	
Baltimore, MD 21215-0036 permit. Pages I and 2 should filed within 72 hours after death with the Maryland Department of Hand and Mella Hygier of the Pages I and 23 a or 28s-f shou Important: If item 27 is marked other than "matural", or items 23a or 28s-f shou injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility		weene un	wal suc
100 10.00		23a, Part I. Inter the disease, or complications that caused the death. Do not entre	8+28 UDUSTO	ac or respiratory arres		MD 21133 Approximate Interval
Physician Medical		failure List only one cause on each line. Narcotic (Oxyc	odone and Hydroc	odone) Int	oxication	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, b				
	E.	if any, leading to immediate Cause. Enter Underlying Cause C. Due to (or as a consequence of): C.				l.
J iit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
recuted n and - transit		d. X UNPENDED 23a,27,28a-f	ner me c917 7-2	1-11 vt		
60, ate be exi hysician e burial -	ed i		рег ше дугу / 2		23d. Date of delivery	
x 6876 h certificat tending phy	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pre	gnancy		Day Year
Box 687 death certifice the attending p	sick	Pregnant at time of death 5	Other (Specify)		2	
D. BC: the dest	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in ti	he underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
P.O.	کر ک			1 Yes	2 No 3 Prob	oably 4 🗹 Unknown
ds, equire	ompleted			24a. Was an		topsy findings available completion of cause of
e law i e has t ge 2 sh	шp			perform	ed? death?	
tal Rec	O	25. Was case referred to medical	26.Place of Death (Che			2 110
of Vital Records, of Physician: The law requir the this certificate has been s neral director, page 2 should 1	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpat	ient 3 DOA Other Nu	rsing Home 5 R	esidence 6 Other	<u> </u>
ing Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time			w injury occurred	
ttendi death. stor:	[읉	Pending Accident Investigation fd 6-27-11 unkn		ulikhowi		and Devide North as City
Division tal or Attendirs after death.	Certification:	3 Suicide 6 K Could not be determined (Specify)	street, factory, office building, etc.	or Town, Sta	ite)	ral Route Number, City
Ospital ospital of hours a uneral I	3	29a. Certifier 1 Certifying Physician: To the best of my knowledge death or	ccurred at the time, date and place.	-		ed
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	tigation, in my opinion, death occurre	ed at the time, date ar	nd place, and due to th	e cause(s)
7 wit 7 00 00 00 00 00 00 00 00 00 00 00 00 00	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		aud 2.	O.C.M.E.		June 28, 2011	
_		30. Name and address of person who completed cause of death (Item 23a)	Delkinson Charles Delkinson	MD 24222		
		Ana Rubio MD. Assistant Medical Examiner 900 W. E		IVID 21223		
S Regis	tate		W.			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Month Physician/ 2:50 AM M George Laurence Moore June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson 8. Date of Birth May 26, 1926 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 🛛 M 2 🗆 F Mary Land 85 **Director** 216-28-6137 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1960 Old Annapolis Road 21797 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 24 No 1 Never Married 2 Married b 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. th and Mental Hygiene. 27 is marked other than "r Elementary/Seconday (0-12) 1 2 farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Laurence Moore Blanche Parlette traumatic Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
960 Old Annapolis Road Woodbine, MD 21797 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh nt of Health a :: If item 27 Is or other trai Nancy Moore/spouse 1960 Old Annapolis Road Woodbine, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If ii any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 🕅 Donation 5 Other (Specify) Signatur Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -cc11 yers disease or condition resulting in death) Medical Due to (or de a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death.

Funeral Director: After this certificate has autopsy death? 1 Yes 2 No □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier NNC 24 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON MO AALON MO 6701 31. Date filed (Month, Day, Year) Registrar's Signatu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Katherine Minnick Margaret 2011 June 6:25 A M Medical 4a. Facility Name (if not institution, give street and number) Nursing Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Dunda1k Genesis Heritage Meridian Home 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Months Days 1 □ M 2 🔽 F 215-28-4082 , 1931 Maryland Director 79 Aug. Usual Residence of Decedent show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Dunda1k 1 ☐ Yes 2X No Baltimore MD 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 8038 Del Haven Road United States 21222 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 9 Years Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theresa Bynes Charles Edward Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8038 Del Haven Road Dundalk, Maryland 21222 Department of Health ar Important: If item 27 is any injury or other trau once. Joyce A. Minnick (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 7/2/2011 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Dona**y**ion 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.

Dundalk Maryland 21222 21. Signature f Funeral Service Lice 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transit and resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director, After this certifical completed filled in by the funeral director, Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending atural 1 Yes 2 No Accidem
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) Dun dalk MD 2/222

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #23a&b Per PHY C917 7705/2011 JH

State of Maryland Department of Health and Mental Hygiene

AMEND #25, PER ME G930 8/8/12 TRT

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1645 Josephine 28 2011 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 31,1955 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F Days Hours Maryland Yrs 215-64-8171 56 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Directo Dunda1k MDBaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code United States 21222 7904 Diehlwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deced Armed Forces? 1 ☐ Yes 2X No Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 9 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail 7 Years Stock Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Krac Adam Mach ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Diehlwood Road Dundalk, Maryland 21222 Mrs. Helen Mach (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) St. Stanislaus Cem. 7/1/2011 Baltimore, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or hear trillure. List only one cause on each line. Spontane us complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician Hemorrhag disease or condition resulting in death) intra cerebral Medical Due to (or as a consequence of) Examiner Coagulopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or, The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXA Due to (or as a consequence of) burial-P.O. Box 68760, Physician/Medical the IF FEMALE: attending nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the at detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed: Jas 1 Yes 2 No 1 Yes 2 No of Vital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural Injury 1 Yes 2 No Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Hospital 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) within 2 To the I the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 June 28,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILDRON 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State barker Registrar

DHMH 17 Rev 1/2001 11595

VET CHAIND HE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Year Physician/ nei 4:20 FM BeHY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 226 Doris Avenue Baltimore N/A 8. Date of Birth July 1952 . Age (In yrs. last birthday) 58 yrs. 9. Birthplace (State or Foreign Social Security Number Sex If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Months Hours Mary land 215-60-5263 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 I No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 226 United States Doris 21225 Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gloria Adams Albert Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Doris Avenue, Baltimore, MD 21225 Gary O'Neil - Husband injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State centre Haventher place) 1 Daurial 2 Cremation 3 Removal from State 7-1-2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Memorial Park 22. Name and Address of Facilit Ambrose Funeral Home, Inc. 21. Signature of Francisco Licenses any 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Liver Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No jo Dav Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed^a 2 🗌 No 2 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 M No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 S Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural injury 5 Pending 1 Yes Accident Investigation after deatl 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MSKijapathen D 00057465 6/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. S. Reyupak & M.D. 283 S. S. M. M. — Baltimore

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

2011

5-703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June ^D2011 21, 1:57 PM M James Price Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Year) Mar 25, 1911 **Funeral** 1 🕅 M 2 🗆 F Hours Director Yrs 220-54-0410 100 Usual Residence of Decedent ital Hygiene.

9d other than "natural", or items 23a or 28a-f show
event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George's Adelphi 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 Metzerott Road 20783 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces Black, White, etc. þ 1 Never Married 2 Married Ves 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 Wildowed 4 Divorced Completed Decedent's Education un 16a. Decedent's Usual Occupation un-16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Carroll Avenue Takoma Park, MD Washington Adventist Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state 28 Partend Adda to fifty lit Board 655 W. Baltimore Street enswife, Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy the atte in the past 12 months?
1 Yes 2 No Year 5 Other (specify) g Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 Ne 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? performed' 1 Yes 2 No ☐ Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 ANO ြု 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after death.

Reference Affector: Affected filled in by the fu 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hore To the Fune completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 Altmins

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death
 Month ecedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2011 almer TUNE 25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CATON NA GENESIS MANOR MO BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Dec. B) yrs. last birthday) 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In **Funeral** Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a State 10h County 28a-f show items 23a or 28a-f showner must be notified at 1 Yes 2 No NIA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA Pages 1 and 2 should be filed within 72 hours after death with 21229 by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed and Mental Hygiene.

is marked other than "natur aumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housina Huthorit laintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Bruce 1055 ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rmant's Name/Relationship (Type. Print) permit. Pages 1 and 2.1 Department of Health a Important: If Item 27 is any Injury or other trauonce. Hibington Ave. 14 N. Balto mo alaze aeraldo <u>raimer</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Catonsville, MD 4 ☐ Donation 15 ☐ Other (Specify) 22. Name and Address 21. Signature of Funeral Service Live 270 Fredhilton Pass Balto MD 21229 Approximate Interval Between Onset and Death 23a. Party Enverthed sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequery Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by A Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed es 20 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 2 •• Flace of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C the Hospital 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 30. Name and dd 31. Date filed (Month, Dav, Year) State Registrar

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036	s after death ral", or items Examiner m	by	1 Never Married 2 Married 1 Never Married 2 If Yes,	Yes 2 X No	Nwas Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) Colleg	eted) (Giv	eedent's Usual Occupa ee kind of work done du DO NOT use retired	tion uring most of workin	sst. 16b.	Kind of Business I	Duty		
and	d be filed v Aental Hyg Irked othe Iic event,	To Be	17. Father's Name (First, Middle, Last) Waddell Goldm	ian		tearl	Russ	n Surname)			
Mary	12 should Ulth and Ma 27 is mar r traumati		19a, Informant's Name/Relationship (Type, Print)	rughter 19b. Ma	iling Address (Street ar	nd Number or Fund	Polis Offing City	or Town, State, Zip	Code)		
ore,	Page 1 and ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 1 4 Donation 5 Other (Specify)	20b. Place of Discemetery, cr	position (Name of ematory) or other place	ne 7/9	Pate 20c.	Location - City or	Town, State		
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. Box 68760	to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		Control of the contro	/		23d. Date of de Month	ivery Day Year		
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Division of Vital Records,	law requi has been e 2 should	Completed					24a. Was an autopsy performed?	prior to	topsy findings available completion of cause of		
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Divisi	to the thospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page:			Place of Injury - At home, farm, suilding, etc. (Specify)	street, factory, office		28f. Location (Street a City or Town, Sta		ral Route Number,		
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	vithi Com		29b. Signature and title of certifier	A MI	29c. License	number 7	2 29d. [ate signed (Monti	70) //		
	3		30. Name and address of person who completed	cause of death (Item 23a) (Type	Print) Le	Rlar	1 Hon	Bynnin	21061		
P	Stat		31. Date filed (Month, Day, Year) 3	32 Aegistrar's Signature	la di	7 Politic		/ -(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edmundson Medical Town, or Location of Death Facility Name (if not institution, give street and numb 4c. County of Death Examiner imore g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Vicarolina Director items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ecedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married Married 1 Yes Baltimore, Maryland 21215-0036 Specify: 1 🗌 Yes 🖎 No 3 Divorced 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20c. Location - City or Town, State 20b. Place of Disposition (Name cemetery, crematory of others) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 1 Burial 2 □ Cremation 5 □ Other (Specify) 21. Signature of Fun Service Licensee Servites 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of 5 ying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ stage End disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter University of Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and dbe detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Vital Records, artery 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 **N**0 Yes 22 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DCA Division 'of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D51788 6-30-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falls Rd \$ 300 Baltmore MD MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 12:45 PM Claire R. Russo June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Towson Gilchrist 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** New York 1 🗆 M 2 🗓 F Months Days Feb. 24 Year 1938 Hours Min 73 131-28-0969 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 🗆 Yes 2 🔀 No MD Timonium Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral items 23a 21093 **USA** 312 Jody Way death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. "natural" 3 X Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Banking Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gertrude Nichols Thomas Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Arverne Court; Timonium, MD 21093 Andrew Russo son 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, Other (Specify) 4 Donation 5 7/6/2011 Oulaney Valley Mem Gardens Timonium, MD 1050 York Road 21. Signature of Fund 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be and hours after death.

Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Be Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗆 Residence 6/1 Other (Specify) 1 ☐ Yes 2 🕅 No LWSDIG မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury Natural 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Physician/ Elizabeth Squirewell 28 201 10p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan Hospital If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01 17 Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Min 1 M 2 W 212-58-1341 O Director MD Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 "natural", or items 23a or Funeral 1428 Riggs Ave 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant|Children's Choice 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Elmon Morgan Ronnie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21217 610 N. Appleton Street Dana Epps-Averette/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/6/2011 Woodlawn, Md King Memorial Park 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signature of Funeral Service Licensee Baltimore. Ave Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Metartatic CA Breast Onset and Death Immediate Cause (Final disease or condition enysician/) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for exit consequence of cause. Enter Underlying Cause (Disease or iinjury burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 I Inknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed 1 Yes 21 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 🗆 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA er of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ram Woods Roa. 881 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ JULY DOLORES A. SMITH 2019 5:35 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE TIMONIUM BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 10/7577978 MARYLAND Director 215-09-5581 92 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 XNo PARKVILLE MD BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8800 WALTHER BLVD. IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Was Decedo... Armed Forces? ⁴ ☐ Yes 2 🗶 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3X□ Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry giene. Elementary/Seconday (0-12) College (1-4 or 5+) STATE OF MARYLAND CLERK should be filed with and Mental Hygien is marked other ti 12TH GRADE injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည CHARLES J. CREANEY EMILY A. FIDDES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 is 2609 JOPPA TERRACE PARKVILLE, MD 21234 MAUREEN D. COLLINS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State NEW CATHDERAL CEM. 7/6/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Lice ee MO1189 nce. 8521 LOCH RAVEN BLVD. TOWSON. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate Drivinto (or as a nonsequence of) If any, leading to immedicause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical certificate be OCLD R ₹ S JYN) + H Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signet (Month. Day, Year, who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) L; Month Year **Physician** 2011 ROBERT C. SCHWEITZER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sal fincs-e amareton 2000 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/20/1925 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. lest birthday) **Funeral** Months Days Hours 1(XM 2□F 86 Director MARYLAND 219-10-0852 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23e 1213 LINKSIDE DRIVE 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X)Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 🗶 No Specify: Specify: aryland 21215-003 3 XWidowed 4 ☐ Divorced WHITE Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then College (1-4or 5+) YEARS Elementary/Secondary (0-12) INSURANCE ADJUSTOR INSURANCE COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ROBERT SCHWEITZER RUTH BEADLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THEODORE SCHWEITZER/SON if item 27 12302 FOX LAKE PLACE FAIRFAX, VA 22033 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1- Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department Important: fl CEDAR HILL CEMETERY 7/7/2011 BROOKLYN PARK, MD Injury * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Solvice Ligensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO1139 any Ir 8521 LOCH RAVEN BLVD. TOWSON, MD no Approximate Interval Between Onset and Death a 1. Enter the dise se, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) . 4 ☐ Pregnant at time of death P.O. detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending after death. 2 🗆 No investigation 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 38956 o completed cause of death (Item 23a) (Type, Print) Lich Raven, Bal fimore, Maryland 2039 60 clek Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 June Physician/ 11:10AM 27 Garry Dehaven Smith Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Joseph Richey Hospice 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year, Hours 1 🌠 M 2 🗆 216-50-3833 Maryland **Director** 61 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Funeral 21202 USA Aisquith Street #14C 633 N. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Completed by 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Services Laborer 9th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James Smith Marcia Henry permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is marl any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1239 N. Central Avenue Baltimore, MD 21202 Deborah Smith/ Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/5/11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ろれの disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No detached g Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Yes 2 No 26. Place of Death (Check only one) or Attending Physician: Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 21 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination allower investigation, and generally specified at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 0 28 1201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, Year)

95 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 8:15 Daniel Scheib, Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death **Examiner** Har a If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** March 5, 1923 1 ★M 2 ☐ F Months Hours Pennsylvania 189-18-6431 88 **Director** Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland rector r 28a-f st notified 1 ☐ Yes 2X No Md. Harford Forest Hill Ö 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 21050 USA <u>3411 Kreitler Road</u> permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ò 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 Kildowed 4 Divorced White Completed 1944 1946 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Courtroom Clerk State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Scheib Elizabeth Mosberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Miller DTR. 3411 KreitlerRd. Forest Hill, Md. 21050 20b. Place of Disposition (Name of cemetery, crematory or other place Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-6-2011 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fun Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that a used the death. D shock, or heart failure. List only one cause on ear h line. t enter the mode of dy he, such as cardiac or respiratory arrest, nterval Between and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ther significant conditions contributing to death but not rever ing in the underlying caus diven in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of autopsy death? After this certificate To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Programment of the Funeral Programment o Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examin 3 Certifying Nurse (Check Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

Year)

O

who, completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:10P M June 28,2011 Sylvia Stephanie Soustek Medical 4a. Facility Name (if not institution, give street and number)
Future Care – 1046 Old Northpoint Rd 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Eastpoint Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral 1 🗆 M 2 🛛 F Min (Month, Day, Year, 2–26–1918 ountry) Marvland Hours **Director** 160-18-6786 Usual Residence of Decedent 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location Director notified Md. 28a-f Balto. Eastpoint 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1046 Old Northpoint Rd. 21224 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. Ь þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify: 'natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Stephen Riha Francis Mucha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Soustek Grandson 113 Meadow Run Knightdale, N.C. 27545 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department or Important; If any injury or Cedar Hill Cemetery 7-5-2011 Brooklyn Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek FuneralHome 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) MEU MOULE nionte Medical Codio Vesala Di Examiner athersdest' Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury -transit engt and that initiated events resulting in death) Last Due to (or as a consequence of) physician are the burial-t Completed by Physician/Medical Box 68760 attending pt for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.0. is been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillah Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy this certificate 1 Yes 2 No Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide М Investigation within 24 hours at er decit To the Funeral Director of completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1) 30555

Registrar

DHMH 17 Rev 7/2009

State

756 North Pint Pel Baltin , NO 21219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Bal), Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ruth E. Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Health System Cumberland Allegany . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 Months Days Hours Min. (Month, Day, Year) une 2, 1935 Maryland 76 June Director 219-30-3998 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 No MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral l Kaylor Circle 21532 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?,
1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry unk College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည John Gray Marie Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Smith/spouse 207 Maple Place Frostburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Little 4.8 Ronal ^{22. Name and Address of Facility}
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury Natural 5 Pending work? 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Smith June スネ 2011 12:41 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital 8600 Old Gorsdavild Belests Johns Hopkins Halin Montowell Counte 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F June 5, Year 939 Pennsylvania Yrs Director 203-30-2055 Usual Residence of Decedent 10c. City, Town or Location or 28a-f short 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 ☐ Yes 2X No Rockville MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 20852 USA 11809 Old Drovers Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 9 þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify white "natural", Completed 3 ☑ Widowed 4 ☐ Divorced Medical unk 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 in and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the I 12 secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Frances Mylott John Paul Lavery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $11809\ 01d\ Drovers\ Road\ Rockville,\ MD\ 20852$ 19a. Informant's Name/Relationship (Type, Print) Christopher Smith/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) re of meral Service Licen 13 de , State and Address of Facility Board 655 W. Baltiore Street 21201 MD Baltimore. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Anoxic Enceptatopathy disease or condition Medical resulting in death) **Examiner** cardio-Pulmonary Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Respiratory failure pneumonia resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD, SIAH, Hypotension 1 Yes 2 No 3 Probably 41 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Vita Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b Time of 28c. Injury at After 1X Natural To the Hospital or Attending 5 Pending work? Division 2 🗌 No L Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number cc J escon 6-22-2011 D17656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7830 Old Georgetain Rd # 013 . Bethesda MD Tipaporn Woodward Mb

Registrar
DHMH 17 Rev 7/2009

State

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31 Per PHY G917 &/05/2011 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Year Skynam Moysey 10:10 PM Steynman Medical 701 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN 5. Social Security Number 6. Sex 1 M 2 F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 97 Hours Min Months 0371471914 213-35-5355 **BELARUS** Yrs Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD BALTIMORE BALTIMORE Examiner must be notified 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 6978 MARSUE DRIVE #2B 21215 USA items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗴 No Black. White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN UNKNOWN STEYNMAN ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLA MINDEL/DAUGHTER 805 JOSHUA TREE COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 07/01/2011 BALTIMORE, MD 4 Donation 5 Other (Specify, 22. Name and Address of Facility SOL LEVINSON & BROS., Sig + any in 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. Part 1. Enter the disease, or complications shock, or heart failure. List only one Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ End-Stage disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 2 🗌 No Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Other: <u></u>은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 🗌 No 2 Accident Investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number MSRijapaneMID 00057465 6/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N . S . Raju pa Ve (M . D . 2835 Smith N 21209. 5203 Baltimore · Rajapakse, MiD. 5 Day 31. Date filed (Month, I ^{Year)} 2011 32. Registrar's Signature State Sarke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 28^{Day} Frances Thacker Marian 2011 June 11:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 1004 Graceview Dr. Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Hours 1 🗆 M 2 💢 F 1 1/23/1929 247-46-1633 81 Yrs Ohio Director Usual Residence of Decedent show 10b. County 10a. State er than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Harford Maryland Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 Graceview Dr. 21078 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Child Care n Child Care Provider other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cora Childs Earnest Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
503 Lighthouse Rd, Perryville, MD 21903 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trees. Yakim / Daughter Sara Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Mem.Gdns. 7/3/2011 Aberdeen 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St. Aberdeen, MD 21001 21. Signature 23a. Part 1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Pnysician/ OVARIAN METHSTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? this certificate 2 No 1 🗌 Yes 2 XN Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA funeral hours after death.

uneral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated соmpleted (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifier

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31. Date filed (Month, Day

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Name and address of person who completed cause of death (Item 23a) (Type, Print) 625

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Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Ruth Ward 3 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner of Manyland Medical Center Baltmore University 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Country) Director 10a. State 10d. Inside City Limits be filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at City, Town or Location Director 1 Yes 2 No 10g. Citizen of What Country? Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ - months dissectiva Portio disease or condition aneurysm Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any backing to immediate cause. Enter Underlying Examine 24 hrs Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Hyperkalemia the burial-transit and Due to (or as a consequence of): attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ the atter in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heparin-induced 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 1 un 67 2011 D007103° 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar MD

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32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 945 Day 8 Month **Physician** ما Sara Wunder om /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Caton Manor Nursing Home

7. Age (In yrs. last birthday) Baltimore if Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🖫 F Days 73 Yrs. Months Hours unk 409-56-4292 09-29-1937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the M-dical Examiner must be notified at 1√2 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21217 USA 301 McMechen Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 McMechen Street Baltimore, MD 21217

Date 20c. Location - City or Town, State Mel Wunder/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Mothex (Specify) in state 21. Signatura of Funeral Service Licenset Ronald Sympace Director State Anatomy Board 655 W. Baltimore Street 200 21201 Baltimore, MD 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Seath Immediate Cause IFinal disease or condition resulting in death) **Physician** neemon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes ¿No In the funeral precion. After this cerminate Funeral Director: After this cerminate Funeral director, pr 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes r 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 4 hours after death. 5 Pending investigation 1 Matural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

HMBN

Lammand 31. Date filed (Month, Day, Year) -- .

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please T	ype or Pri								gible.	
			For State Registrar	State of Ma	arylanc			nt of F e of E		vientai Hy	giene Reg. No.	Banday stocks	21182
			Decedent's Name (First, Middle, Last)				timou.	0 0/ 2		2. Date of De	eath		3. Time of Death
	Physicia Medio		Christine F. Will	Liams						June	23, Day 201	1 Year	4:56 AMM
	Examin	er	4a. Facility Name (if not institution, give str Stella Maris	reet and number)				Town, or	Location of Death			nty of Deat altim	
	Funeral Director		214-03-3178	M O MT C	e (In yrs. las 95	st birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bit Apr 23	rth ay, Year 916		thplace (State or Foreign untry 1 and
	nd show at	۱	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside City Limits
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	ith the 3a or 3 t be no		10e. Street and Number	ar Dood			10f. Z	p Code 2109	33		10g. Citizen	of What Co USA	ountry?
	ems 2	Funeral	2300 Dulaney Valle	2. Was Decedent E	ver in U.S.	. 13. V	Vas Dece		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No			erican Indian,
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 【【】 If Yes, Give Year or Dates.	No				n, Mexican, Puerto	Rican, etc.)	Spec	llack, White hify: w l	e, etc. nite
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212	within giene. er thau		Elementary/Seconday (0-12)	College (1-4 or 5	+)		nemal				own	home	
/land	d be filed voluntal Hygarked otheric event,	To Be	17. Father's Name (First, Middle, Last) Harry George Fin	dling					18. Mother's Nan	ne (First, Middle Ann Spi		ame)	
Baltimore, Maryland 21215-0036	nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationship (Type Robert E. Willia		n	19b. Mailir 1512	ng Addres Dot	ss (Street a nega1	and Number or Rui Road Be	al Route Numb	er, City or Town	n, State, Zi 14	p Code)
			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	lemoval from State		ace of Dispo emetery, cren			ce)	Date	20c. Location	on - City or	Town, State
Balt	permit. Page Department of Important: If any injury or		21. Signature of Euneral Service License	de Dir	ector				omy Board		. Balti	more	Street
			23a. Part 1. Enter the disease, or complic shock, or neart failure. List only one	cations that caused cause on each line	d the death e.	. Do not ente	er the mo	de of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	hysician/ Medical	0 19	Immediate Cause (Final disease or condition resulting in death)	LIVER									Onset and Death
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		edical	d	l									
. Box 68760	The law requires that the death certificate be are has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3	Ctopic Other		су		23d.	Date of de Month	elivery Day Year
ls, P.O.	v requires that th s been signed by should be detac	þ	Part II. Other significant conditions con	tributing to death b	out not resu	ulting in the u	underlying	g cause gi	ven in Part I.		tobacco use c		o the cause of death?
of Vital Records,	sician: The law req certificate has bee irector, page 2 shou	Completed								per	s an 24 opsy formed?	prior to death?	utopsy findings available completion of cause of
alF	ian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. P	lace of Death (Che		2 2 140	1210	3 2 2 10
Ž	this ald	은	1 Ves 2 XNo	ospital: 1 Inpati 28a. Date of inju		ER/Outpatie			4 ☐ Nursing F				cify) HOSPICE
	Te Te	cate	1 X Natural 5 Pending 2 Accident Investigation	(Month, Da		injury	M	28c. Injur worl 1 [28d. Describe	how injury occ	curred	
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7	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completed filled in by the fu	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 X Certifying Nurse	er: On the basis of e	examination	and/or inves	stigation, i	n my <mark>op</mark> ini	on, death occurred	at the time, date	and place, and	I due to the	cause(s) and manner stated
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			30. Name and address of person who co			23a) (Type, I		707	TIMONT	UM, MD	21002	70	- 1.5
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 5 2011	2 Registr				T VD	TIMUMI	ori, fil	21033		

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State of Maryland / Department of Health and Mental Hygiene

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	hysicia	n/	Decedent's Name (First, Middle, Last)					2. Date of D	eath	-	3. Time of Death
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المجمد	Examin	er	1416 Sussex Road			4b. City, Town, or Essex	Location of	Death	ĺ	Baltimo	
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land	show	tor	10a. State 10b. County	10c. City, Tov	wn or Loc	ation					10d. Inside City Limits
Mary	28a-1 notifie	Director	Maryland Baltimore	Essex	K					-	1 🗌 Yes 2 🕅 No
vith th	23a ol st be	ral	10e. Street and Number			10f. Zip Code 21221			"	Citizen of What Co	ountry?
leath v	items er mu	Funeral	1416 Sussex Road 11. Marital Status 12. Was Decedent Farmed Forces?			as Decedent of His	spanic Orig	in? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ame	
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hydiene.	han "l e Mec	omp	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	i+)		ind of work done do NOT use retired)	uring most	of working			
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Marylan should be file	rked o	인	Joseph Charles Yanish, Sr	_				inia Minni			
and M	7 is marketraumatic		19a. Informant's Name/Relationship (Type, Print)		9b. Mailin	Address (Street a		r or Rural Route Numb			p Code)
	N .	- /	Michele Guzman (Sister)				oad 1	Essex, Mar	_		
<u>_</u> _ 0	<u>'</u> = 5		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State	cemei	tery, crem	ition (Name of atory or other place		Date 07/01/2011		Location - City or	
Baltimore, permit. Page 1 and Department of Hea	Important: any injury once.		4 Donation 5 Other (Specify)	Bayvi		rematory Name and Address		eral Home		altimore	, Maryland
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			23a. Part X. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	9.							Approximate Interval Between
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VIta ysicia	is cert direct	To Be	examiner?	ent 2 🗆 ER/0	Outpatient	Othe	r-	rsina Home 5X Re	sidence	6 ☐ Other (Spec	cify)
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JIVIS all or A after	l Direct		4 Homicide determined 200: Place of Inju-	c. (Specify)	iaiii, stie	er, ractory, office		City or To	wn, Sta	arid Number of Hi ate)	irai noute ivanibei,
DIVISION Of VITAL He To the Hospital or Attending Physician: The I within 24 hours after death.	To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e	my knowledge	e, death o	ccured at the time,	date and p	place, and due to the curred at the time. date	ause(s)	and manner as st	ated. cause(s) and manner stated.
the trithin 2	the F	Me	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier				e time, date		the caus		s stated.
Ę Ż	F 8		David Silver	Dr.			1 4	234			(, 2011
5+	/		30. Name and address of person who completed cause of d			int)		,			/
9			DAVID S 12 VEX DO	1 3	901	Thek	719 h	neda, B	9/7	Imore	81216 am
	Sta [.] Registra	ie ar	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Junte 11, ™2011 Bobbie Dale Adkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles 11707 Lancelot Drive Waldorf Social Security Number if Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2XX Months Days Hours 240-38-0154 82 0373071929 North Carolina **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Charles 1 Yes 2 XXVo Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11707 Lancelot Drive 20601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 XXIo Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 KNo Specify: White "natural" Completed 3XX Widowed 4 □ Divorced Specify: d 2 should be filed within 72 hours a sulth and Mental Hygiene. n 27 is marked other than "natural er traumatic event, the Medical E: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fingerprint Division Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norman Tatum Addie L. Singletary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Heinzel / Son-in-Law 1 and 2 sof Health item 27 8418 Woodlawn St. Alexandria, Virginia 22309 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 06/19/2011 Singletary Cemetery 4 Donation 5 Other (Specify) Butters, N. Carolina 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur of Funeral Service Ligenses alka 6160 Oxon Hill Rd. Öxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I industries Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 X Xo Pregnant at time of death 4 Pregnant a 9 Unknown 5 Other (specify) Month Day Year 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig ; page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 1 ☐ Yes 2 ☐ No Yes director, of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 x Residence 6 Other (Specify) e Hospital or Attending Phys 124 hours after death. e Funeral Director: After this oleted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XXVatural 5 Pending Division Accident 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral Completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Krishan

Maithur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16201

32. Registrar's Signature

31. Date filed (Month, Day, Year)

11-04739	
Rosalee Butler	

Please Type or Print in Black Indelible Ink. Ensure Aii Copies Are Legibie.

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Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Middle,Last) ROSa		isti	ne :	Butler			Date of Deat Month June 25, 2	h Dav Year		of Death
		4a. Facility Name (if not institution, give 57 Woodlyn Road	street and number)		1	b. City, Town, o				4c. County of Cecil	Death	
Funeral Director		5. Social Security Number 222-52-8617 6. Sex	,	yrs. last b	oirthday) Yrs.	If Under 1 Ye	ar If Under		8. Date of Birt	th (MM/DD/YYYY)	9. Birthplace (Foreign Country)	State or VA
An A	ŀ	Usual Residence of Decedent 10a. State 10b. County	100	. City, Tov	vn or Locati	on					10d. In	side City Limits
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with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 57 Woodlyn Road	B			10f. Zip Code 2191	1		10	Og. Citizen of Wha	t Country?	
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Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service License	-		22. N	an e and Addres	ss of Facility	Hicks	s Home	1939 for Fun Elkton,	erals,	F.A. 1921
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	ŀ	30. Name and address of person who con Zabiullah Ali, M.D. Assist:	mpleted cause of death ant Medical Exam	. 1/		altimore Stre	eet, Baltim	ore, ME	21223			
Sta Registr		31. Date filed (Month, Day, Year)	32. Régistrar's S	gnature	pa	Nes .						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04725 State of Maryland / Department of Health and Mental Hygiene Robert Vernon Baron 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 2146 hrs June 24, 2011 Medical Examiner Robert V. Baron 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Chesapeake City Cecil 605 2nd Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours country)Delaware Director 02/10/1984 222-66-6970 1 X M 2 F 27 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Y Yes 2 No Smyrna Delaware Kent t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene.

reant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once, or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 19977 446 Smyrna-Clayton Boulevard 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status 12. Was Decedent Ever in U.S. White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes Specify: White 1 Yes 2 No specify: 4 X Divorced f Yes, Give Year <u>a</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Construction Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Baron Be Robert Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 446 Smyrna-Clayton Boulevard, Smyrna, DE Catherine Baron/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, July Date 1. 20a. Method of Disposition Brandywine Vallev 1 Burial 2 X Cremation 3 Removal from State 2011 Wilmington, DE Cremation Care 4 Donation 5 Other Specify: 22. Name and Address of Facility Nicks Home for Funerals, F.A. 21. Signature of Funeral Service License 103 W. Stockton Street, Elkton, MD 21921 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician Between Onset and** failure. List only one cause on each line. /Mudica Death a Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g917 7-7-11 sm X UNPENDED the attending physician and for use as the burial -Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by the best of the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral periods in the signeral period period periods in the signeral period period period periods in the signeral period period period periods in the signeral period period period periods in the signeral period period period periods in the signeral period perio Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à Completed 24a. Was an 24b. Were autopsy findings available certificate has been ector, page 2 should prior to completion of cause of autopsy death? director, page 2 2 No Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurre After 27. Manner of Death subject fell off the dock into Certification: 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A 1 Yes 2 X No Pending Fd 6-24-11 Fd 9:46 pm 128e. Place of Injury - At home, farm, street, factory, office building, etc. in by the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 605 2nd St. determined (Specify) in water of canal Cecil, Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 25, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 471 M Janet M. Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min 1 □ M 2 🖾 F Days 09-22-1921 88 Pennsylvania Director 201-18-4108 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🛱 Yes 2 🗌 No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 50 Summet Ave. Suite 109 21740 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖈No Specify: Specify: Black "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Page 1 and 2 should be fill trent of Health and Mental rtant: If item 27 is marked outpry or other traumatic ew ပ Josh Brown (unknown) Sara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent E. Brown (son) Box 4203 Hagerstown, Maryland 21741 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Thomas L. Geisel Crem. Department o Important: If any injury or 06-27-11 Chambersburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas L. Geisel Funeral Home Faneral Service Licens 333 Falling Spring Rd., Chambersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (a Exami The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No g Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 24 hours after death.
Funeral Director: After this certificate I 2 🗌 No 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2011 M Sherman J. Belt 0 2151 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Davs Hours Director 219-54-7261 Maryland Usual Residence of Decedent 28a-f show 10b. County filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1917 H Copeland 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th 0 City of Annapolis Operations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I. Important: If item 27 is marked of any injury or other traumatio and Mental F မ James Belt Hazel Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl M. Belt(Wife) H Copeland St. Annapolis, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 6 - 17 - 11Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname a Recomment Sons Mortuary, P.A. Signature of Funeral Service Licensee Larry 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First Middle | ast 2. Date of Death 3. Time of Death Month Physician/ OBERT W EIVNING JOIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, r Location of Death Examiner 4c. County of Death Mandrin Hospice House Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Days Months Hours Min. 172871930 Director 215-28-0905 81 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes XX No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 931 Edgewood RD. Apt. 108 21403 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 Black, White, etc. 1 Never Married 2 Married 1XXYes 2 No 1950-Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White and Mental Hygiene. Is marked other than "natural", If Yes. Give 3 Divorced 4 Divorced 1954 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Area Supervisor BGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Robert Henry Benning Josephine Morland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadine Benning Wife Edgewood Rd. Apt 108 Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodfield Cemetery 6/17/2011 Galesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service (10) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Enter the disease Approximate Interval Between Immediate Cause (Final Physician/ PANIMA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
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To the Funeral Director: After this completed filled in by the funeral dit 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at HOUSE 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes ☐ Accident ☐ Suicide Investigation Could not be 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Praction the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certife 29c. License number 21438 a un Name and address of person who completed cause of death (Item 23a) (Type, Print) -La 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 6 2011

DHMH 17 Rev 7/2009

Registrar

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Funeral		5. Social Security No		3. Sex 1 M 2 □ I	7. Ag	ge (In yrs. las		If Und	ler 1 Year Days	If Under Hours		8. Date of B	irth Dav. Year	1)			e or Foreign
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Baltimore, bernit. Page 1 and bepartment of Hea mportant: If item my injury or other note.		20a. Method of Disp 1 🛣 Burial 2 [Removal fro	om State	cei	ace of Dispo metery, cren	natory`or	other plac			Date	20c.	Location -	City or	Town, State	
Itim it. Pag interint injury		4 ☐ Donation 21. Signature of ur				Ft.						/2011		rentwo		MD	
Baltimo permit. Page Department of Important: If any injury or		21. Signature of un	eral Scholce LL	ensee						ss of Facili ain H		all Fu Bow			2071	5	
		23a. Part 1. Enter th	ne disease, or c	mplications that	at caused	d the death.							<u> </u>			Approxim	nate
· Chysician/	5 31	shock, or hear Immediate Cause (F disease or condition	inal	y one cause on	each line	e.										Interval B Onset an	d Death
Medical Examiner		resulting in death)		a. Due t	to (as	a conseque	Her ence of): se R		1000	1						341	
	<u>.</u>	Sequentially list cor	nditions,	b. Er	nd	Sta	se R	en	al c	dis	eas	e				591	<u>S</u>
ed sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or ii	lying Injury	Duell	o (or as	a conseque	fice of):	1:4	1.4							40.	110
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876 tifficat ng ph as th	Med	IF FEMALE:			J												
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		23b. Was decedent print the past 12 mm 1 Yes 2 Tes 9 Unknown	nonths?		/e Birth egnant a		death 3	Ectopic Other (s		у				23d. Dat Moi		very Day	Year
P,C	y P	Part II. Other signific					_	nderlying	cause giv	en in Part	I.	23e. Did	tobacco	use contr	ibute to	the cause of	death?
ds, quires en sig	ed	teriphe	ial Va	Scula	nd	isea	use,	M	en	la		1 t	Yes	2 🗆 No	3 🗌 Pro	bably 4	Unknown
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on on on on on on on on on on on on on o	icate	1 ☒ Natural 2 ☐ Accident	5 Pending	(Mo	onth, Day	y, Year)	injury	М	28c. Injury work 1 🔲			8d. Describe	how inju	ary occurre	ed		
Divisic tal or Atter rs after des al Director led in by th	Medical Certificate:	3 Suicide 4 Homicide	6 Could no determine	t be 28e. Plac	ce of Inju	ury - At hom c. (Specify)	e, farm, stre	et, facto	ry, office			28f. Location (City or To			r or Rura	il Route Nur	nber,
Hosp 24 hou Funer eted fil	edici	(Check 2		hysician: To the uminer: On the b urse Practions	asis of e	xamination a	and/or investi	gation, in	my opinio	n, death or	ocurred at	the time date	and place	ce and due	to the co	use(s) and r	nanner stated.
To the somple		29b. Signature and ti		di se Practicina	, to the	A Comment	inciwinoge, u	$\overline{}$	c. License		Hario piasi	Cand die to t		ate signed			
		> Va	rail	· Mu	KI	rel	mo		D44	099	2		4	0/17	4/2	011	
Sylv.		30, Name and address	ss of person wh	o completed ca	use of d	eath (Item 2		int)				anbe	all.	5. M	5	210	 54
State Registra	e	81. Date filed (Month)	JUN 17	2011 32.	Ry istra	ar's Signatur	å 1	all	1	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State 25 Maryland / Department of 17 and 2011 tah bygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DAVID ARTHUR BREEDING 2:20PM 2011 DUNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE ST AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign CHFCAtCO ILLINOIS 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days Hours 348-68-5436 44 Director NOV. 14,1966 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exandred 1. ust be notified at 1 X Yes 2 No Director MARYLAND CECIL ELKTON 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code UNITED STATES 21921 102 GILPIN AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 \(\overline{\text{TYes}}\) 2 \(\overline{\text{No}}\) No If Yes, Give \(\overline{1}\) 984-85 Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify. Specify: WHITE ≥ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING STEEL FABRICATOR 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) JOANNE SPRUNGMAN HENRY CLINT BREEDING ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. 102 GILPIN AVENUE, ELKTON, MARYLAND ERIN BREEDING / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JUNE 20. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 □ Donation 3 [2011 NEWARK, DELAWARE MAYERDALE CREMATORY rvice Licenses 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Traumatic Brain Injury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENCEP 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ∐ Yes 2 💢 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -2 XNe 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Subject operator of motorcycle struck pick-up truck

28. Location (Street and Number or Bural Route Number, City or Town, State) Holabird Avenue near Stengel Ave., Dundalk, MD 1 X Natural 5 | Pending 1 □Yes 2 X No 4:42 2 Accident 3 Suicide 01/20/2010 a^{M} investigation within 24 hours after deat To the Funeral Lirector: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Roadway 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

DHIVA

(Check only one)

29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

law requires that the death certificate be execute

P.O. Box 68760.

Records.

Division of Vital BREEDING

Hospital or Attending Physician:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00065861

HAMMONDS FEERY RD BALTIMORE, MD 21227

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Henrietta E. Batson 2035 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WIGMIG MONSE PSICAL TENINSULA If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign Social Security Numbe MD Country) **Funeral** Days Hours Month, Day, Year) - 26 – 1924 1 □ M 2X□ F Months Director 215-26-4383 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 🗌 Yes 2 🔀 No Rhodesdale Dorchester MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21659 USA 5915 Bethel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Spec**B**:lack 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Henrietta Rideout Robert Trott, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5915 Bethel Road, Rhodesdale, MD 21659 Tanya Batson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 6-17-2011 Rhodesdale, MD Cokesbury Cem Donation 5 Other (Specify) Pennie Smith W. Isabella St. uneral Service Licenses Ignature of Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple organ dusfunction disease or condition resulting in death) Medical Due to or as a cons ruence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ttending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Il or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached a | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Encephalopathy, Hypoglycemia, Sepsis 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗷 No Medical Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 \square Pending Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

enun

29c. License number

10070961

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alma Patricia Bacon 201 5,25 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** comico spice a 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 - M 2 1 F Days Min Maryland 11/07/1925 215-20-1394 Director 85 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Maryland Wicomico Mardela Springs 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21837 513 Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by Yes 2 X No Hatricia Bacon Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: white If Yes, Give Year or Dates 3 ¥ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Paper Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Thelma Carey Joseph Woodrow Willard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Colaine Dr., Aberdeen, MD 21001 19a. Informant's Name/Relationship (Type, Print) Marita Watts/sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Mardela Memorial 1 X Burial 2 Cremation 3 Removal from State 6/18/2011 Mardela Springs, MD 4 Donation 5 Other (Specify) Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PHLMONARY DISRASR CHRONIC OBSTRUCTIVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine rany, Isability to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(\text{HOSPICE} \) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred work 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completed f (Check 🥱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) id title of certifie 29b. Signature D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 130 X Hupm WAN Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2011

JUN 17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:30 PM Corine 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Johns Hopkins Howard County General Hospital Columbia, MD Howard If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 SXF Hours Country) Virginia 09010 Pay 1932 Director 172-26-9832 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Kyes 2 No Columbia Md. Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral hours after death with U.S.A. 6228 Copper Sky Court 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. State Department Clerical filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 1 and 2 should be fif Health and Mental Fletcher Sadie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2. Department of Health an Important: If item 27 is 6228 Copper Sky Court, Columbia, Maryland Brooks - Daughter Gina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Pk 6-23-2011 Elkridge, Maryland 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature of Funeral Service Licenses 10583 Middleport Lane, White Plains, Md. 20695 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Atheroscleratic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine lany leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 | Unknown the is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 X Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No certificate nours after death.

Interest Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ျှ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 X Natural Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 ho To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) D066866 JUN 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yvette N. Owens 5755 Cedar Lane, Columbia, MD 21044 31. Date filed (Month, Day, Year, JUN 2 1 201 State Registrar

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 26 2011 June 1145 A^{M} Kathleen Ellen Chenault Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 E1kton Union Hospital 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** July 11, Year) 942 1 🗆 M 2 👿 F Pennsylvania 68 Director 177-32-6711 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant, If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 X No E1kton Maryland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21921 United States 108 Bowling Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. ρ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify White Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mobile Home College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Human Resource Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Isaac Penn Helen Hetherington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Autry W. Chenault/Husband 108 Bowling Lane, Elkton, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 30 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 2011 West Chester, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕱 No 1 Yes 2 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1. Natural 5 \square Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) 00062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 AUGUSTINE HERMAN HWY, SUITEA, C KHAN SHAHNAWAZ 31. Date filed (Month, Day, Year) State Registrar

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Division of Vital Records, P.O. Box 68760 ral or Attending Physician: The law requires that the death certificate be rs after death.	by Pr	Part II. Other signif		contributing to death I	out not res	ulting in the	e underlyin	g cause giv	en in Par	rt I.					ne cause of death?
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	Medical	(Check 2	Medical Exam		f my know examinatio	ledge, deat n and/or inv	h occured estigation,	at the time	, date and	d place, an occurred at	d due to the c	ause(s)	and manner ce, and due t	as state	d. use(s) and manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 18 2011 06 12:11PM Jerald M. Crossan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Harford Memorial Hospital Havre De Grace If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Davs Hours (Month, Day, Year) L2-29-1932 Director 78 DE 221**-**18**-**9323 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No MD Cecil Rising Sun 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 3 Park Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give 1 (Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Year or Dates. 1951-56 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Estimator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James Crossan Beatrice Seldomridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Park Circle, Rising Sun, MD 21911 Mary Crossan - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) .T.Foard Funeral Home, P.A. Rising Sun, MD 22. Name and Address of Facility R.T.Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee S. Queen Street, Rising Sun, MD 21911 23a. Part 1 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner curse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ■ Yes 2 □ No 3 ☑ Probably 4 □ Unknown Completed 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 2 WNO 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 140 မ 1 Yes 1 Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director; and completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State Registrar 12351na

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -Month Year Physician 6:30 AM June 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Haven Nursing ton6VIIIe Home timore Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1□M 2 F 227-62-7536 8-25-1946 Director 64 VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f showner must be notified at 1 ☐ Yes 2 X No Director Wicomico Fruitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21826 USA 505 Sharps Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 0. 1 □ Yes 2 No Baltimore, Maryland 21215-0036 speBnlack ģ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) the Production Worker Campbell Soup Co 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be James E. Church Catherine Giddens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is Kathy Lewis/Daughter Sharps Point Road, Fruitland, MD 21826 505 injury or other 20b. Place of Disposition (Name of cemetery, crematory or othe place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Direct Cremation, 6-23-2011 Dover, DE 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith any in Funeral Home Salisbury, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, List only one gause on each line. Approximate Interval Between Onset and Death THERDSCLEROTIC Immediate Cause (Final disease or condition resulting in death) ARDIO VA DISEA Physician Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has e 2 autopsy PULMONARY performe DISEASE 10 Yes HRONIC certificate OBSTRUCTIVE Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 128595 Wellen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALD MD 21209

Registrar DHMH 17 Rev 1/2001

State

ASN 31. Date filed (Mont 2835

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Natasha Copper Certificate of Death 1- For State Registrar 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0944 hrs June 14, 2011 **Medical Examiner** Cooper Natasha 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Country 08-15-1977 Director 2X F Arkansas 1 M 33 431-39-4285 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No Washington 28a-f show hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number s 23a or 28a-f e notified at o U.S.A. 20019 3227 D Street, SE 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married Yes Specify: Black 1 Yes 2 No specify: If Yes, Give Year or Dates: 4 Divorced 3 Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is month. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Metro Access Dispatcher 2 18.Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Lest) Buchanan Samuel Lewis Cooper æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7704 Fanwood Court, District Heights, Md. Tawanna Cooper - Sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/23/11 Washington, D.C. Olivet Cemetery 4 Donation 5 Other Specify 22. Name and Address of Facility Ronald Taylor II Funeral Home ignature of Funeral Service Lic 10583 Middleport Lane, White Plains, Md. 20695 seeme, or camplifactions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician en Onset and failure. List only one cause on each line. Death /Medical a. Acute Coronary Artery Dissection Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Postpartum State Sequentially list conditions, Due to (or es a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial -Box 68760, 23d Date of deliver 23c. If yes, outcome of pregnancy IF FFMALE: 23b. Was decedent pregnant in the 1 V Live birth 2 Fetal death past 12 months? Pregnant at time of death ~ June 6,2011 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> О 1 Yes 2 No 3 Probably 4 V Unknown 쥧 Completed 24b. Were autopsy findings available Division of Vital Records, 24a Was an certificate has been ector, page 2 should prior to completion of cause of autopsy performed? death? 2 No 1 🗸 Yes ✓ Yes 2 No 26. Place of Death (Check only one) 25 Was case referred to medical director Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient DDA 2 🗸 ER/Outpatient 3 this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Certification: 1 🕢 Natural 1 Yes 2 No 5 Pending within 24 hours after death. To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie June 15, 2011 O.C.M.E. Vai 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 31. Date filed (Month, Day, Y

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Rosa Mae Florence Campbell 1^{6} , 20116:35 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 2613 Silverdale Drive If Under 1 Year If Under 24 Hrs 8. Date of Birth 1941 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Davs Hours February 18, Washington, D.C. Director 579-52-5904 70 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 X Yes 2 No Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2613 Silverdale Drive 20906 ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U.S. Department of alth and Mental Hygiene.

27 is marked other than er traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Defense Human Resource Specialist 2 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Beulah Edna Stadler Luther **Florence** Ernest permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Park Vista Court; Silver Spring, Maryland 20906 Tonna Angelina Norman (DAughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 22,201 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral S Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 6 months Pnysician/ Metastatic Breast Cancer to Liver disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Month Pregnant at time of death 9 Unknown 9 Unknown signed by the detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has performed Yes 2 X No ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital: 2 **X** No <u>|</u>e 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending nours after death. neral Director; Aff I filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 31. Date filed (Month

only one)

29b. Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Drive; Suite 506

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c, License number

D37236

Bethesda, Maryland

29d. Date signed (Month, Day, Year)

June

17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elizabeth Eng		1- For State Registrar	State of Ma	iryland / De	epartm Certific	nent of Ho	lealth a	ind Men	ntal Hy		2 0 eg. No.	• Contraction of the Contraction	2120
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Maryl:	Director	10e. Street and Number					f. Zip Code			11	Og. Citizen of Wha	at Cour	
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ours af atural	þ Þ	45 Daniel B	or Dates:		d) 16a. [1 Yes Decedent's Us	2 X No			rk done	Specify: 16b. Kind of Busi	Whi	
5-0036 lled within 72 hou Hygiene. l other than "nai the Medical Ex	Completed	Elementary/Secondary (0-		ge (1-4 or 5+)		during most of	f working life	fe. OO NOT L	use retired	i)	160. Кіпа от визн	nessur	idustry
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MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than tumatic event, the Medical tumatic event, the Medical	2	19a. Informant's Name/Relat	ationship (Type, Print))	19b	. Mailing Add	ress (Stre	ELLZo	abetui	1 Marga	ret Mich	als	ska
		Elizabeth M.	Engleman/N		115	88 Lod	lge Po	ole Cou	urt,	Annapo	olis, MD	214	Zip Code)
Ore, es lar of Her tr		20a. Method of Disposition 1 Burial 2 X Crema	ation 3 Remov	/al from State	0b. Place of	f Disposition (f ery or other pla	Name of cer	metery,			20c. Location - C		
Baltimore, permit. Pages lar Pepartment of Hecimportant: If ite		4 Donation 5 Othe	er Specify:	M		Cremat	ory	1	06/24	/2011	Baltimor	e,	Maryland
Bal permi Depar Impo		21. Signal re of Funeral Serv	vice licensee			22. Name a	and Address	s of Facility	Beal	1 Fune:	ral Home	2	
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/Medical		failure. List only one car Immediate Cause (Final disea			Min E.	Sittor a.c.,	16 Ol aj'e,	Suu i as	(CIAC OI 100	spiratory and	t, shock, or near		Approximate Interval Between Onset and
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ited d ansit	E	events resulting in death) La	ust Due to (or a	as a consequence	a of):							- 1	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	adical	X UNPENDED	a	_D 23a,27,	per n	ne.g917	7 7-1!	1_11 s	m			-	
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Box e death the atter	ysic	1 Yes 2 No 9 ✔ (Unknown	egnant at time of d iknown	death 5	Other (Sp	pecify) _				P		
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三 道 语 点	BB.	25. Was case referred to medi examiner?					26.Place	of Death (Ch	heck only		No 1 🗸	Yes	2 No
of Vir	P	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	-				Nursing Hor			ther:	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral director.	Certification:	1 X Natural 5 Pe	ending (Mont	ate of Injury nth, Day,Year)	28b. Hm	ne of Injury		y at Work? es 2 No	- 1	Describe how	injury occurred		
ivision or Atten after death Director:	fica	2 Accident Inv	vestigation	ace of Injury - At h	home, farm	street, facto	_		1	I section (Stee		-	2
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To the Hospital within 24 hours To the Funeral completely filled	_ 2	29a. Certifier 1 Certifying one) Certifying	Physician: To the be	est of my knowled	dge, death	occurred at the	ne time, dat	e and place,	, and due t	to the cause(s) and manner as s	stated.	
To the within To the comple	BL	one) 2 Medical Example 29b. Signature and title of certif	and manner	s or examination a	and/or inves	estigation, in m	ny opinion, c	death occurr	red at the t	time, date and	place, and due to	the ca	ause(s)
		19b. Signature and little of Certif	1. / OI 0	1		29	9c. License				d. Date signed (A		Day, Year)
		30. Name and address of person	- Hall	200-			O.C.M.	I.E.		J	une 22, 2011		
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Registr	εli	JUN ~ U	12011 /	here	A. A	acked	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	iato of maryia	Ce	rtificate	of De	ath	u	i.u. i i j gir	Re	g. No.		
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		4a. Facility Name (if not institution		mber)			y, Town, or	Location of	of Death				
		York Road & Bentley		- · · · ·			rkton	Lieur	out lo	Jone 23, 2011 Vear			
Funeral Director		5. Social Security Number		7. Age (In yrs. I	last birthda	· —	nths Day			ate of Death onth onth 2 2011 Ac. County of Death Baltimore County Date of Birth(MM/DD/YYYY) Date of What Country? U.S.A. Pes or No- Date of What Country? U.S.A. Pes or No- Date of Business/Industry Automotive Date of Business/Industry Automotive Date of Business/Industry Automotive Date of MD 21120 Date of MD 21120 Date of Mortuary, Irrical State of Mort	n		
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Maryland 28a-f show d at once.	ţ	MD Ball 10e. Street and Number	Ltimore		I	Parkt	Zip Code			I 10	a Citizon of W	hat Coun	
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shoulk at it is in it	ဥ	19a. Informant's Name/Relations											
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once		Brian S. Fos	ster/Fath				Name of cer						
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Box 687 e death certific the attending I ed for use as the	Sic	1 Yes 2 No 9 Un	4 Pregna	ant at time of de	eath 5	Other (S	pecify)						
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Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a possible on the funeral director, page 2 should be a possible of the funeral director.	Certification:	dete	na not be	Roadway	omo, iam,	street, lact	bry, ornice o	anding, etc	- 1	or Town, Sta	ate)		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		aminer:On the basis of	f examination a									
F. E. S.	¥	29b. Signature and title of certific	and manner sta er	1		7	29c. License	number			29d. Date sign	ed (Moni	th, Day, Year)
		Cel	uns	2/7	,		O.C.N	И.E.			June 23, 20	011	
	ł	30. Name and address of person	who completed cause	e of death (Item	23a)								
		Zabiullah Ali, M.D.	Assistant Medica	al Examiner	900 V	V. Baltim	ore Stree	et, Baltir	more, MD	21223			
	ate	31. Date filed (Month, Day, Year)	32.	istrar's Signatu	ire	arks	7						
Regist		JAF 0 3	2011	me /							nci	WE	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carol Foster 14 2011 9:45 June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c, County of Death Anne Arundel Linthicum Tate Chesapeake Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan . 06, 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 X Months Hours Director 047-22-7365 81 1930 Connecticut Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director items 23a or 28a-t sr ner must be notified Severna Park MD Anne Arundel 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 509 Harlequin Lane permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker **Home** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot rother traumatic ever ည Olive Saxton Edwin Sevin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health are; If item 27 is 509 Harlequin Lane Severna Park, MD 21146 Diane W. Newman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, June 21, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Department of Important: If any injury or Norwich, CI 4 Donation 5 Other (Specify) Maplewood Cemetery Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) asular Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, been signature 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform the Hospital or Attending Physician: The hin 24 hours after death. the Funeral Director. After this certificate Inpleted filled in by the funeral director, page Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar vame and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month TUNE Physician/ 1:58 PM <u> Alexzenia Freddie</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** CHARLES CIVISTA Social Security Number MBDICAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. July 10, Ye. Texas **Director** 83 1928 466-36-7019 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director XX Yes 2 No Maryland
10e. Street and Number Waldorf <u>Charles</u> 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 20603 5021 Doctorfish Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than College (1-4 or 5+) Elementary/Seconday (0-12) Telephone Operator 12th. other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked ည Pearl Alexander <u> Alexander Brouders</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$021 Doctorfish Ct. Waldorf, MD. 20603 <u> Alexzenia Williams/ D</u>aughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place June 20, 2011 El Paso, Texas 4 ☐ Donation 5 ☐ Other (Specify) Bliss Nat. Cem. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between is and Peath Immediate Cause (Final 10 Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Year Month Day 5 Other (specify) this certificate has been signed by the a ral director, page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **1** No Qinpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 1 Tyes 28a. Date of injury (Month, Day, Year) . Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Fractions 1.1 to best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Fractions 1.1 to best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZA

State

Registrar

M#476036

32. Reastrar's Signature

JUN 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward L. Fooks 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omico bur 8. Date of Birth 9. Birthplace (State or Foreign I Security Numbe Age (In vrs. last birthday) Funeral Min. Maryland 1 Ϊ M 2 🗆 F Months Hours 09/11/1921 220-09-1050 89 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Maryland Wicomico Salisbury 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21801 418 Somerset Ave. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Army/ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates. AirCorp 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Flight Officer Airlines Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Fannie Marvel Samuel Lee Fooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7625 Cortina Ct., Carlsbad, CA 92009 John Fooks/son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State any injury or 6/17/2011 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CERBBROVASCULAR Physician ACCIDENT disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deep burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 Yes Completed certificate has been si rector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 NO Yes 1 Yes 26. Place of Death (Check only one) completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 2/1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this or Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatur

State Registrar

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address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 12:38PM June William T. Gosnell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Washington Medical Center Washington 8. Date of Birth Sept. 23, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1931 Marviand Director 79 220-26-6604 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director be notified or 28a-f 1 X Yes 2 □ No Maryland | Prince Georges Accokeek 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Examiner must 20607 USA 17808 Livingston Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 M Yes 2 No. Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married "natural", or Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 11th. Lift Operator Boating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be f Welby Gosnell Margaret Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 James Gosnell/ Brother 17808 Livingston Rd. Accokeek, Maryland 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury June 20, 2011 Accokeek, Maryland 22. Name and Address of Facility 21. Signature of Euneral Service Licensee ^{22. Name and Address of Facility} Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. mp1190 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALCIO Pulmonney disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Asch, ThmiA MADIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of; the burial-transi Heart ONGWAVE and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performed' Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 - No 은 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🖁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Swers 6/15/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7137 ivingston Washingto MD 31. Date filed (Month, Day, Vear) State **JUN 21** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 100 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 18 2011 Mary Jean Groover 6:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) 1 □ M 2 **X**) F Month, Day, Year 1927 Director 220-12-3867 83 VA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 □ No Prince Geroges Lanham 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6607 Chestnut Avenue 20706 United States items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🚺 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, <u>the Me</u> Elementary/Seconday (0-12) College (1-4 or 5+) Retail Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jasper G. Oldham Lillie P. Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pauline Stern/ Daughter 2403 Cool Spring Road Hyattsville, MD 20783 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | 06/21/2011 Brentwood, MD 4 Donation 5 Other (Specify) Signature of Fundal Service Correct 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) led by the si detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown DNE COSONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔲 No DICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at 5 Pending ☐ Natural ohair 2 Accident may 23 2011 1 Yes 2 No Investigation 6 Could not be 1030 Suicide 28e. Pace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Signature and title of certif 2011 MO OME Name and address of person who completed cause of death (Item 23a) (Type, Print) MOOME 31. Date filed (Month, Day, Year, State 1 201 JUN 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty June 15. Day 011 Ann Hartnett 11:33 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 833 Shelby Drive Prince George's Oxon Hill Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Min. Hours 577-42-9643 79 3/128/P19/32 A la Bama **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 Shelby Drive 20745 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 2 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gaylord Hugh Lovvorn Thelma Crowell any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Raymond Thomas Hartnett 17 Cosgrave Ct. Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 6/21/2011 Edgewater, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home, P.A als 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. P 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ___ Month Pregnant at time of death Day Year 1 ☐ Yes 24 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 DNO Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 10005095

Division of Vital

Box 68760

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Reverdole MD 2013/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IVUM Medical 4c. County of Death Prince George's 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 11504 Accolade Court Clinton . Social Security Number 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 M 2 220-34-7592 81 2/2871930 MaryTand Director Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's Clinton Maryland 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 20735 11504 Accolade Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 4 Yes 2 rces? 2 No RET re 1974 ates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Military Chief Warrant Officer Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or care 18. Mother's Name (First, Middle, Maiden Sumame) Morris မ Ruth Granville W. Horsey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11504 Accolade Ct., Clinton, MD 20735 Barbara Dashiell Horsey -Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Arlington National Cem. 7/15/2011 Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signat a. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Unidenying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No the 9 Unknown g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been sig r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate h
completed filled in by the funeral director, page 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 1 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year O 8. Name and address of person who co ompleted cause of death (Item 23a) (Type Print 5 DEFENSE HWY. JENEVIEVE

State Registrar 31. Date filed (Month

1 6

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:08A M Ida Mae Harris 2011)une /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Princess Anne Somers If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs 3-12-1930 215-26-2636 81 **Director** MD Usual Residence of Decedent death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, If a Medical Example and could be realified. 1 □Yes 2\\\¬No MD Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30380 Maple St, Apt 205 21853 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 X No Specify. Spec Black 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Laundry Aide Laundry Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William Gillette Helen Holden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11986 Somerset Ave, Princess Anne, MD 21853 Rose White/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Supreme Council
House of Jacob Cem6-18-2011 Princess Anne, MD 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hoūse Bennie Smith W. Isabella St. 21. Sign ture of Funeral Service Licensee Funeral Home Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician FIB. COSIS PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred I or Attending F after death. 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 13th 2051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3TM

Registrar
DHMH 17 Rev 1/2001

State

DR. USHA NATESAN

31. Date filed (Month, Day, Year)

Registrar's Signatu

1415 - S. DIVISION ST, SALISBURY, MOMBOY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	S	State	of Mary						and N	/lental H	ygien	e 20		010	212
		Registrar 1. Decedent's Name (First, Middle	. Last)				Cen	iricat	e of D	eatn		2. Date of D	Reg. N	lo(AC	6 1 C	16
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-/ <u></u>		Union Hospital 5. Social Security Number	6. Sex		7 Age (In)	yrs. last birth	hday)		lkton	l If Under	24 Hrs	8. Date of E	Disable.	Се	cil	anless (Chris	- F t
Funeral Director		196-28-2643		1 2 □ F	73		Yrs.	Months		Hours	Min.	Month, L April	Day, Year)	938	Penr	nplace (State o intry) 1 Sy 1van	r <i>Foreig</i> n ia
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partition is, with yield a 1212-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Janet M. Johns										al Route Numl Sun, M		or Town, 1911	State, Zip	Code)	
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Medical Examiner		disease or condition resulting in death)	f a	Due to		nse luence o			mer		1		-	1.			
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ath certifica	ın/Me	IF FEMALE: 23b. Was decedent pregnant			tcome of pr	egnancy Fetal death		Fatanta	. Sand .					23d. D	ate of deli	very	
that the death led by the atter detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 Preg	nant at time	e of death		Other (s						М	onth	Day Y	ear/
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To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director, After the completed filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	xaminer:	On the bas	sis of examir	nation and/or	r investig	gation, in	my opinio	n, death oc	curred at	the time, date	and plac	e, and di	ue to the ca	ause(s) and mai	nner stated.
To the within com		29b. Signature and title of certifier	7	MI	D				c. License	- ()	190	2		1/2	4/11	Day, Year)	
,		30. Name and address of person	who comp	eted caus	se of death	(Item 23a) (T	Type, Pr	int)	= LL	50 11 4	1/14	N P.1.=	CAC	1465	APEAI	XECITY 21915	MD
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State of Maryland / Department of Health and Mental Hygiene

Cortificate of Dogth

		•	For State Registrar	State of Ma	aryland		artment <i>tificate</i>			and M		gien Reg. N	7111	21213
	Dhysisis	n/	1. Decedent's Name (First, Middle, Last,)							2. Date of De	ath		3. Time of Death
	Physicia Medic		AGATHA	HOKE		JER	OME				Month	26	2011	1050 A M
	Examin	er	4a. Facility Name (if not institution, give s	treet and number)			4b. City, T	own, or L	ocation o	of Death		4	c. County of Dea	ath
	Funeral		FREDERICK MEN 5. Social Security Number 6. Sex	MORIAL HOS	SPITAL e (In yrs. last		FR If Under	EDER 1 Year	TCK If Under 2	24 Hrs. T	8. Date of Bin	th.	FREDER	TCK rthplace (State or Foreign
	Director			☐ M 2 🔀 F	96	Yrs.	Months	Days	Hours	Min.	(Month, Da Nov. 2	Year)	1914 Mar	ountry) Vland
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	or 28a notif	Dire	10e. Street and Number	K	rred	erick	10f. Zip (Code			T	10~ (itizen of What C	1 X Yes 2 □ No
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	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	Vas Decede	nt of Hisp	panic Orig	gin? (Spec	cify Yes or No-	011.	14. Race - Am	erican Indian,
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	Hosp 24 ho Fune eted fi	Medical	(Check 2 L Medical Examine	cian: To the best of n er: On the basis of ex	amination ar	nd/or investi	aation, in my	opinion.	death occ	curred at t	he time, date a	nd place	e and due to the	cause(s) and manner stated
	o the vithin o the complex	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: to the b	est of my kr	nowledge, de		d at the ti		and place			(s) and manner as ate signed (Mont	
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			30. Name and address of person who co		ath (Item 23	la) (Type, Pr	int)			(/	· /
			A Austin Pearre		ow		5+	Fre	ede	rich	c, mo) 6	21701	<u></u>
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DHMH 17 Rev 7/2009

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7			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	June 20, 26	4c. County of Death	
			18331 Honey Locust Circle	Gaithersburg		Montgomery	
	Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last b		s. 8. Date of Birth	h(MM/DD/YYYY) 9. Bir	hplace (State or
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	w any		10a. State 10b. County 10c. City, Tow	on or Location			10d. Inside City Limits
	Maryland 28a-f show	و ا	MD Montgomery Gaithe	ersburg			1 X Yes 2 No
	Mary 728a rd at	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	try?
	The second and a second or the Maryland store death with the Maryland sent of Health and Mental Hygiene "natural", or items 23a or 23a-f sho mrf. If kem 27 is marked other than "natural", or items 23a or 23a-f sho mr other traumatic event, the Medical Examiner must be notified at once.		18331 Honey Locust Circle	20879	τ	ISA	
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	an Indian, Black,
	or it	1 2	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
•	s arre	۾	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Bla	ack
	"natr	Completed	15. Decedent's Education (Specify only highest grade completed) 16a Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret 	work done	16b. Kind of Business/Ir	idustry
ဗ္ဗ	than	e e	Elementary/Secondary (0-12) College (1-4 or 5+)		12		,
유	giene ther	Ę	17. Father's Name (First, Middle, Last)	ommunications Technic		AT & T	
21215-0036	E E E	Be	Edward P. Oxendine		(First, Middle, Ma		
212	Men	10			lenderson		
B S	27 is	1	l	9b. Mailing Address (Street and Number or 2719 Ameila Avenue, I	Kurai Route Numb	er, City or Town, State,	Zip Code)
6	A said 2 should be litted within /2 hours are Health and Mental Hygiene. item 27 is marked other than "natural", I traumatic event, the Medical Examiner.	l	20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,		20c. Location - City or T	oum Ptoto
JO.	Department of Healt Important: If item injury or other train	l	1 Burial 2 Cremation 3 Removal from State crema	atory or other place)			
iti.	ortan		4 Donation 5 Other Specify 21. Signeture of Funeral Service Licensee	t & Son FH & Cr 07/	03/11	Buford, C	S A
~	i F	ļ	Lenge Though	22. Name and Address of Facility Sr	owden Fu	neral Home	
	sician	_	23a. Part I. Enter the disease, or complications that caused the death Do n failure. List only one cause or call time.	246 N. Washingt	On St,	ROCKVIIIE	
	edical		9 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			, shock, or near	Approximate Interval Between Onset and
=X8	miner		or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Cardiovascular Diseas	e		Death
		L	Sequentially list conditions, b				
		ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
D		Examine	(Disease or injury that initiated events resulting in death) Last				
P	ı and - transit		d.			į	
e execu	ician a	dical	x UNPENDED X AMENDED 23a,27 per	me g917 7-21-11 vt	<u>. </u>		
760 ate b	physic the bu	¥	IF FEMALE: #/ocircle 6/28/11 • FMW N	/h(^)			
Box 68760 e death certificate b	e attending p for use as th	cian/Me	23b. Was decedent pregnant in the past 12 months?		ncy	23d. Date of delivery Month Da	y Year
OX eath c	atten for us	Sic	1 Yes 2 No 9 V Unknown				,
e e	by the c	Physi	9 Onknown				
P.O.	signed by	<u>a</u>	contributing to death but not resulting	g in the underlying cause given in Part I.		cco use contribute to the	
duire duire	en sig	ted			1 Yes	2 No 3 Probab	oly 4 🗹 Unknown
DO WE	has been a	륍			24a. Was an autopsy		osy findings available apletion of cause of
Rec The l	cate	Completed			performe 1 Yes 2	d? death?	
<u></u>	s certificate rector, page	8	25. Was case referred to medical examiner?	26.Place of Death (Check of		No 1 ✓ Yes	2 No
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate by	al dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Other Nursing	Home 5 Res	sidence 6 🗸 Other: S	cene
D I	After		1 X Notice (Month, Day, Year)	Fime of Injury 28c. Injury at Work?	28d. Describe how		
ig gi	y the	ij	Pending Accident Investigation	1 Yes 2 No			
i N Y ≥	Direct Direct I in by	븳	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.	28f. Location (Stree	et and Number or Rural	Route Number, City
	hours after ineral Dir y filled in	Certification:	4 Homicide determined (Specify)		or Town, State	*)	
e Ho	e Fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and o	lue to the cause(s)	and manner as stated.	
To th	Within 24 h To the Fur completely	Medical	and manner stated.	vestigation, in my opinion, death occurred at	the time, date and	place, and due to the c	ause(s)
		≥	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
			Chief C	O.C.M.E.	J	une 21, 2011	
			30. Name and address of person who completed cause of death (Item 23a)				
			Ana Rubio MD. Assistant Medical Examiner 900 W	/. Baltimore Street, Baltimore, MD	21223		
	Sta Regista	ate	31. Date filed (Mooth, Day Year) 2011 37. Registrar's Signature	backed.			

DHMH 17 Rev 1/2001

OCME -

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 20b per fb 9917 7-5-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ JAMES KLINE 2011 1220 A M UNF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical centar If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, 1 ₩ 2 □ F Mary land **Director** 212-38-8485 May Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at Funeral Director 1 🗆 Yes 2 🕅 No Hancock Washington Md. 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or than "natural", or items 23a or the Medical Examiner must be r 21750 U.S.A 14736 White Oak Ridge Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ve 56-58 Black, White, etc. þ 1 Never Married 2 🛛 Married 1 X Yes 2 If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry e 1 and 2 should be filed within 73 of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Frances Blickenstaff Lloyd Roland Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14736 White Oak Ridge Hancock, Md. 21750 Judith A. Kline (Wife) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Smithsburg Crematory Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. M01414 Davis Funeral Home Smithsburg.Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ injury Anoxic Brain Medical resulting in death) Due to (or as a consequence of) Examiner Hemothorax Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to or as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Gastrointestinal Bleed 24a, Was an autopsy this certificate has page 2 performed Yes 2 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 M No Hospital: Other: 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) AU417645K19658 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) south Greene St. Baltimore 21201 Kahntroff stephanie 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fh g917 7-5-11 vt.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No: Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 1845 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Regional Medical Hilegany umberlana If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-19-1930 6. Sex 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 X M 2 X Hours Country) **PA** 196-22-9136 81 Yrs. **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bedford PA 1 Yes 2X No Bedford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 529 Pine Ridge Road 15522 United States or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces?
1 X Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Agnes Nancy McCleland Arthur Devlin Lynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 529 Pine Ridge Road, Bedford, PA 15522 Doris J. Lynn, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Cremation Society of A 7-1-2011 Harrisburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Auer Cremation Services of PA Inc 21. Signature of Faneral Service Licenses Jonestown Rd, Harrisburg, PA 17109 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phyllician/ disease or condition aoxi Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and -trar that initiated events resulting in death) Last Due to (or as a consequence of) burial-t attending physiciar I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page, perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 🗌 Yes Other: ည 11 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Datersigned (Month, Day, Year) SUDKEER SANKOMMU 06973 6125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12501 Willowbrook Road Cumberland, Maryland 21502 Sanikommu MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give stree Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Nov 14 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 1947 Maryland 219-40-3076 63 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or Items 27 s marked other than "natural", or Items 270 mental. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 21 No Maryland Directo Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21403 USA 10 Edelmar Dr Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: Black ð 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Co. Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Social Worker Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian V. Carroll James L. Booth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 370 Winmeyer Dr. Odenton, Md. 21113 Laniel Brown(Daughter) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Memorial Park 6-18-11 Annapolis, Md. 4 Donation 5 Other (Specify) Windame Reverse of SaciliSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1922 Forest Dr. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed attending physician and for use as the bunal-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 - Ectopic pregnancy Live birth Month Year signed by the atter ild be detached for in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No Yes 1 TYes this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 28a. Date of Injury ie Hospital or Attending Pin 24 hours after death. Medical Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3
Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated To the I within 2 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHS

Sean Jackett

JUN 1 6 2011

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 2011 June 11, 9:30P Rhea Helene Langston Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 132 Main Street Lothian Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours 9428 14935 230-50-7581 Director 75 Greece Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Lothian 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 132 Main Street 20711 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give 3 Widowed 4 X Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Murry's Steaks Transportaion Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kostas Karitsinos Maria Evagelou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 Brinkley Station Drive Temple Hills, MD 20748 Morgan H. Langston, Jr/Per. Rep 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/2011 Edgewater, Maryland 21. Signatural Funeral Service Lion 22. Name and Address of Facility George P. Kalas Funera 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Kalas Funeral Rome NU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician, Onset and Death sease KINSOF disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 24 hours after death.
La hours after death.
Lineral Director: After this certificate has been sign beted filled in by the funeral director, page 2 should be beted filled in by the funeral director, page 2 should be Hypercholesterol 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗆 Yes 2 🗆 No Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မှ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 Tes 2 No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Squature and title of certifie 29d. Date signed (Month, Day, Year) H0052843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter A Swaby 13 _MD michellocle 20716

State

Registrar

31. Date filed (Month, Day, Year) JUN 16 2011

back

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month June 2011 A^{M} Richard Eugene McGill 0130 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurelwood Care Center E1kton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Year) 932 1 X M 2 □ F Days Min SEPT 16. Delaware Director 271-30-8522 78 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3514 Churchville Road 21001-1030 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. Civilian Employee of Elementary/Seconday (0-12) College (1-4 or 5+) the United States Navy Mathematician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked of Russell C. McGill Lucy Cope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If Item 27 is Patricia P. McGill/Wife 3514 Churchville Road, Aberdeen, MD 21001-1030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 27, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury o R. A. Ferris & Co., Inc. 2011 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death DEMENTA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SEPSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) funeral director Hospital 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number b. N. Nance J 000 65733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records.

Division of Vital

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene? 220 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WILLIAM JAMES MILLER 5:52 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 XM 2 🗆 F Hours 6/29/1962 215-72-4345 48 **Director** Maryland Usual Residence of Decedent 28a-f shov 10a. State 10h Counts 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Darlington MD Harford 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral items 23a 4318 Conowingo Road 21034 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 3 Widowed 4 Divorced "natural", or 1 Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ¬No Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Restaurant/Retail Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas O. Poole Ruby S. Wagoner 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is any injury or other transone. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby S. Poole/Mother 4318 Conowingo Road, Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) Dublin So. Cem. 6/28/2011 Darlington, MD 21. Signature of Faner 22. Name and Address of Facility Kovert Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Athero sclerotic coranary vascul 1 hours Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if an Jeadin to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of: and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined building, etc. (Specify) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0053568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake 10ff HOMPSON Begistrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Harold A. Molz June 14. 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Sunrise Assisted Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) (Month, Day, Year) 01/20/1924 1 X M 2 - F 212-20-9647 87 Maryland **Director** Usual Residence of Decedent 28a-f show 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Anne Arundel Annapolis Maryland 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 21401 800 Bestgate Rd., #216 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 X Widowed 4 Divorced White Year or Dates 1942-58 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Graphic Arts Salesman vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Julia R. Kailer Otto Molz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 174 Rosalie Drive, Grand Junction, CO 81503 Suzanne Evans/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 Burial 2X Cremation 3 Removal from State Kalas Crematory 6/21/11 Edgewater, Maryland injury o 4 Donation 5 Other (Specify) 21. Signate of Funeral Pervice License 22. Name and Address of Facility George P. Kalas Funeral Home any 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami and -transit Cause (Disease or injuthat initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death led by the a detached f Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 🗶 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living 5 Pending work' 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 418/6 June 16, 2011 154! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Island RD 2140 0/5 MD 139 Solvenons MD 4. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 16a per th 99177-13-11 vt
State of Maryland / Department of Health and Mental Hygiene 11 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13 Pay Physician/ ゴルnonth Nanze 2011 2240 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Mon 1050 9 Dryesy Security Number 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. g. Birthplace (State or Foreign Country) 6. Sex 1 ★ M 2 □ F 8. Date of Birth Funeral Months Days Min 1073071914 213-38-4171 96 Vrs Director IN Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d, Inside City Limits Director notified MD 1 Yes XX No Montgomery Kensington 10e. Street and Numbe 10f. Zip Code ö 10g, Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be r Funeral 4813 Flanders Ave. 20895 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Armed Forces?

1XXYes 2 No WWII 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired)

Printing Specialist

Draftsman and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Gov't Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Orval Nance permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic Arvilla Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Flowers Daughter 18 Willow Spring Dr. Edgewater, MD 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Maryland Veterans 6/16/2011 Crownsville, MD 21. Signature of Funeral Society Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. once, 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Un Medical resulting in death) Due to (or as a consequence of): ma **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last ð Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 Yes John Nance Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident JUD 13 2011 2 X No 2-a// Investigation 6 Could not be UかK 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ruar Poute Number, City or Town, State) determined Home Kengin mo Medical st of my knowledge, death occured at the time, date and place, and due to the cause (s) and mainer as stated. bask of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: 29a. Certifier (Check Certifying Nurse the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signakui e of certifier 29d. Date signed (Month, Day, Year) 13 224 101244576 30. Name and address of person who completed ca e of death (Item 23a) (Type, Print) Dr. Ian Driscoll 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 7 per fh g917 7-5-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 215PM 2011 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washir Health MSD If Under 24 Hrs. Hours Min. 8. Date of Birth Sep 27, 1919 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1□M 2XF 578-14-8051 South Carolina 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or items 23a or 28a-if show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No DC Washington DC Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 14. Race - American Indian, 724 Farragut St. N.W. 20011 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Black Specify φ. 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ford Johnson Annie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Troy Townsend-grandson 2506 Pierce St. Apt 2B Hollywood, FL 33020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 6-14-2011 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Rome 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final erebrovasc Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence infi-Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2√ No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Î No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending investigation 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 014 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gladys Pinover Η. 1:45 A M June 14. 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Severn Severn Anne Arundel Harmonicare Assisted Living at Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** New York 1 □ M 2 XF Months Days Hours Min. (Month, Day 73 Director 123-30-2232 Oct. 06,1937 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Severn 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 844 Stevenson Road 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Herbert Heineman Elizabeth Munson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Scott Pinover / Son 5201 Abingdon Road Bethesda, MD 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 16, 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Baltimore, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. . Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. P 41 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORONARY ARTERY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to impede cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consecuence of death certificate be executed ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Hospital or Attending Physician; The performe death? 2 🗌 No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 5513 ပ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural thours after death.

uneral Director: Afte ed filled in by the fune 5 Pending work? 1 \(\superstruct{\substruct{\sunstty}\sinct{\substruct{\substruct{\substruct{\substruct{\substruct{\subs 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier npleted 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 7531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veteras milersville 21108 State **JUN 17**

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ D349 John Henry Rose 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Meritus Medical Center Washington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
VA 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 400-46-8856 Hours 6/10/1936 1 😾 M 2 🗆 F 75 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Boonsboro Washington MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8436 Tusings Way 21713 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 XMarried þ Specify: White If Yes, Give Year or Dates 1 Yes 2X No Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Olzie Deel George Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Emorv Rose 11512 National Pike, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Penneral Sente) or white (Awa) 20c. Location - City or Town, State 2 Cremation 1X Burial Donation 5 ☐ Other (Specify) 6/21/201 Burkittsville, MD Service Liden 22 Dona Adres Br. Fac Thompson Funeral Home POB 18, Middletown, MD 21769 Part 1. B ter the dise se of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one large on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ nemonia aspiration disease or condition days Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 44 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 si performed 1 ☐ Yes 2 KNo Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No ဂ္ 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 028365 6-17-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

15 H 4F1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

368

need stull-itagester 1910 21746

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

been signed by the attending physician and should be detached for use as the bunal-trans

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:

Division or Vital Records, P.O. Box 68760,

	- State Registrar			Cei	rtificate c	f Death	7		Reg. No	20		21	226
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cal						June	4c. County of Death						
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10 6	Je	esse Kimb	le			R	issie	Kettei	man				
-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Str	et and Numi	her ar Rur	al Route Numb	er City	or Town	State Zin	Code)	
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			1001 701										
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	21. Signature of Funeral Service Lic		CHUL	22	2. Name and Ad	dress of Facil	lity 71m	marman	And	Con	Elmon	ol Um	o Trac
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Sic	1 ☐ Yes 2 🗷 No	4⊟Pregna 9⊟Unkno	int at time of dear	th 5L	Other (specify							,	
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Ž.	Part II. Other significant conditions	contributing to dea	ath but not resulti	ng in the ur	nderlying cause	given in Part	1.	23e. Did 1	obacco	use cont	ribute to th	ne cause o	f death?
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a	29a. Certifier Certifying F	Physician: To the l	est of my knowle	edge, death	occurred at the	e time, date a	and place,	and due to the	cause(s	and ma	anner as s	tated.	
dici	(Check only 2 Medical Ex-	aminer: On the ba	sis of examination	n and/or in	vestigation, in n	y opinion, de	eath occur	red at the time,	date an	d place,	and due to	o the cause	e(s)
Medical Certification:	29b. Signature and title of certifier	and maille	. outou		200 Lin	ense number		[204 D-	to cia	d (Adonth	Day V	
	200. Oignature and the oi certifier								∠∋u. D8	Le signe	u (WONTH),	Day, Year)	
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	30. Name and address of person wh	o completed cause	of death (Item 23	Ba) (Type.	Print)				í				
		shing tov	APR .	7	Print) 47 No.	thorn	Aux	nue t	fac,	str	iwn (11)2	-1742
ite	31. Date filed (Month, Day, Year)		gistrar's Signatur	1	. /				-1	- 600	,		. 70

DHMH 17 Rev 1/2001

State Registrar

JUL 0 5 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ rous 110 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anchorage Nursing & Rehab Wicomico Salisbury 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) Months Days Hours Min. 11-29-1952 1 □ M 2 💢 F Director 58 214-66-8134 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits irector 1 🗆 Yes 2 🗶 No Salisbury MD Wicomico Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 Vine Street USA 315 E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", If Yes Give SpedBlack 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Jones permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Lillie Farlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saint Paul's Place, Brooklyn, NY 11226 Tonya Mann/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Flower Hill Cem 6-18-2011 Eden, MD Bennie Smith Columbia Isabella St. 21. Signature of Funeral Service Licensee Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SRI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical inding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death 5 Other (specify) Day Year signed by the a d be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρΛ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law cate has page 2 s yes 2 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending hours after death. Ineral Director: Al 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined filled in k e Funeral Medical 29a. Certifier Ϊ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D 57952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Babilal Das. 106 Milford ST. # 504B, Solisbury, MJ 21804 31. Date filed (Month, Day, Year) 32. R gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JUN 20 2011

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per verbal G917 7/5/11 TT

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay Joi Month Physician/ 305 М Medical 4a. Facility Name (if no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4NNE AKUNDEL ANNAPOLIS ARUNDER CENTER MEDICAL 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 ☐ M 2 🗹 F last birthday) Yrs. Age (In yrs. **Funeral** Country) ECHOSLOVAKIA (Month, Day, Year) Months Hours **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No CROWNSVILLE 10g. Citizen of What Country? 21032 CEDARWOOD ·S-A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 🗌 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WhITE 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) لىرىر HOME OMEMHILER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ KATRENIC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARRY SPIRKO CROWNSVILLE MD. Z1032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Durial 2 Cremation 3 Removal from State W. ARUNDEL CREMATORY 6-20-11 ODENTON, MID. 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Pineral Service Acenses 22. Name and Address of Facility DAURhERTY FUNCTOR HOME 2601 MOUNTAIN RD. PASADENA, MD. 21122 M00942 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final MRTERY DISEASE Physician/ Severe PERLIPHERAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or de a consequence of, any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: Of the basis of examiner and of investigation, in my spinion;
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of dertifie 29d. Date signed (Month, Day, Year) 29c. License number U06675 person who completed cause of death (Item 23a) (Type, Print 30. Name and address of Timoth Medi MD 2001 Check 31. Date filed (Month, Day, Year 32. Recentrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $201\mathring{1}^{\text{ear}}$ Physician/ June 14 8:40 Рм Dorothy Jean Spessard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 515 Jefferson St Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗶 F Months Days Hours Min. March Mary Land 220-30-9777 76 Director Usual Residence of Decedent or items 23a or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No Maryland |Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 Dual Highway 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 N Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) House Manager State Government 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Turner Catherine E. Shafer McCauley permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Jefferson St. Hagerstown, MD 21740 Lisa Thompson-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6-20-2011 Boonsboro Cemetery Boonsboro, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Vears Immediate Cause (Final Physician Metastatic Pancreatic Cancer years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 10 years Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been sinned by the attending his minimum. has been signed by the attending physician and ge 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\text{Other} \) Other (Specify 1 Tyes 2 IX No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29 DOO 68995 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Registrar's Signatu

1130

1-and

Hagerstown

Amend #4a, 28f	. P	er ME alth Dept Please Type or	Print in Blac	k Indel	lible ink	. Fnsu	re All Co	nies Are l	egible	Y	
Anthony R. Sim	6		f Maryland / D	epartm	ent of H	lealth ar			Logibio		21230
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Certific	ate of D	eath		2. Date of	Reg. No.		3. Time of Death
Medical Exam		Anthony R. S.	im, Jr.					Month June 1		Year	0627 hrs
		4a. Facility Name (if not institution, give s 7908 Bellhaven Avenue		Ar		City, Town, o Pasadena	r Location of D	leath		County of Deat	
Funeral		5. Social Security Number 6. Sex	7908 Belhaven 7. Age (In	yrs, last bir	thday)	f Under 1 Ye		4Hrs. 8. Date of	- 1	DD/YYYY) 9. Bi	thplace (State or
Director		217-46-3926 ₁₋₃ N	ı 2∏F 52	2	Yrs.	Months Day	ys Hours	Min. 03/1	1/195	9 Co	Maryland
an y		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	or Location						10d. Inside City Limits
	ъ	MD Anne Aru	ındel	Pas	adena						1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	ZODIJO		10	Of. Zip Code 2112	22		10g. Citiz	zen of What Cou USA	ntry?
with the	ra D	7908 Belhaven Av	2. Was Decedent Ever	in U.S.	13. Was D			(Specify Yes o	r No-		ican Indian, Black,
death '	Funeral	1 Never Married 2 X Married	Armed Forces?	No				erto Rican, etc.)		White, etc.	
ural",	ğ	3 Widowed 4 Divorced If 15. Decedent's Education (Specify only	r Dates:	ed) 16a.		s 2 X No	o specify: ation (Give kind	of work done		Specify: Williams Sind of Business/	nite
5 72 hou al Exa	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	-	during most	of working life	e. DO NOT use	retired)	102.1		
.003(within giene.	Completed	12 17. Father's Name (First, Middle, Last)			Mecha	inic	40 Maihada N	ame (First, Midd	llo Maidan	Power F	'Idiil
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Healin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be C	Anthony R. Sim, Si	î.					an Bell		surname)	
D 21 should I and Mer	6	19a. Informant's Name/Relationship (Typ	•	1.0						ty or Town, State	
B, MD and 2 sho feelth and traumati		Catherine A. Sim , 20a. Method of Disposition	13	20b. Place	of Disposition	n (Name of ce	emetery,	Date	adena,	MD 211 ocation - City or	ZZ Town, State
MOre Pages 1 ent of F nt: If		1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State		tory or other Crema		INC. J	une 04, 2011	Ba	altimore	e, MD
Baltimore, pernit, Pages I ar Department of Hee Important: If ite	H	21. Signature of Funeral Service License			A company from the company			P.A. S	everna	a Park F	uneral Home
Physician	B 10	23a. Part I. Enter the disease, or complication	ations that caused the o	death. Do no	495	Ritch:	ie Hwy,	S	everna	a Park,	MD 21146 Approximate Interval
/Medical Examiner		failure. List only one cause on each Immediate Cause (Final disease a. Co	line. ontact Gunshot W	ound of	Head						Between Onset and Death
		h	e to (or as a consequer	nce of):			-				
	ner	sequentially list conditions,	e to (or as a consequer	nce of):							
I is	Examiner	(Disease or injury that initiated	e to (or as a consequer	nce of):							
executed ian and ial - transit	_	d. UNPENDED AMENDED									
3760, ficate be execute g physician and s the burial - tran	Medi	IF FEMALE:	23c. If yes, outcome of	pregnancy					23d	. Date of deliver	,
Box 68760 e death certificate be the attending physical of or use as the bu	cian/	3b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	of death	Fetal o		Ectopic pre	egnancy		Month I	Day Year
Box ie death the atte	Physician/Medical	1 Yes 2 No 9 Unknown	9 Unknown		- Guioi	(Specify)		· · · · · · · · · · · · · · · · · · ·			- 8
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici piletely filled in by the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring the funeral director.	þ	Part ii. Other significant conditions co	ntributing to death but	not resulting	g in the unde	rlying cause	given in Part I.				the cause of death?
Cords, law require that been since a should b	Completed							24a. V			topsy findings available
Reco The law icate has	omo							p	utopsy erformed? es 2 No	death?	
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner?	pital: 1 Inpatient :	(=)			e of Death (Ch				
of Vil g Physic fler this teral dir	ဥ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury		utpatient 3 Time of Injury		Iry at Work?	28d. Descr	be how inju	nce 6 Other	r: Scene
ion (tendin leath.	ation	1 Natural 5 Pending 2 Accident Investigation	FOUND: Jun 1, 2011		JND: 7 hrs	1	Yes 2 V No	Subject s	hot self		
Division of Vital Records, tal or Attending Physician: The law requirns after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	3 ✓ Suicide 6 Could not be	28e. Place of Injury -			ictory, office I	building, etc.	28f. Location	n (Street arn, State) 70	nd Number or Ru 208 Bellhav	ral Route Number, City en Avenue
Division Hospital or Attend 24 hours after death. Funeral Director:		4 Homicide 29a, Certifier 1 Certifying Physician	(Specify) Single To the best of my kno			at the time, d	ate and place,				
Division of To the Hospital or Attending Physhin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	one) 2 Medical Examiner: 0	n the basis of examinat ad manner stated.	ion and/or i	nvestigation,			ed at the time, d			
	2	29b. Signature and title of certifier	0/1/	1 mo	80	29c. Licens O.C.				ate signed <i>(M</i> o 2, 2011	ntn, Day, Year)
0.0		30. Name and address of person who con	pleted cause of death	(İtem 23a)		L					
CHLE			stant Medical Exa		900 W. B	altimore S	Street, Balti	more, MD 2	1223		
St Regist	ate rar	31. Date filed (Month, Day, Year) 201	32. Registrar's Signature	- A	par	KN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 June Carrie J. Schoolfield 10:00pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehab Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🛣 F Months Days Hours Min. 2-23-1918 Director 212-66-2103 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Worcester Pocomoke City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Newtown Apts #3 21851 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Schoolfield, Carrie Baltimore, Maryland 21215-0036 Spec Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping <u>Domesti</u>c Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Merrill Estella Teagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21851 <u>Estella Schoolfield/Daughter</u> 407 Maple St. Pocomoke City. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) James UM Cem 6-18-2011 | Pocomoke, MD 22. Name and Address of Facility Bennie Smith Funeral Home 21. Si pature of Funeral Service Licensee 917 W. Isabella St. NOU Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner So, we fielly list our elflors if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 attending physi d for use as the b IF FEMALE: yes, outcome of pregnancy
Live Birth 2 L Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 XNo

9 Unknown Month Day Year Pregnant at time of death signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s performed certificate Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Hospital: Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 X Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury 1 X Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse productioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) R 135131 June 13,2011

Registrar

State

Healthway Dr., Berlin,

MD

21811

9715

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Savage,

Pennie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrate 10e 10f PerFHPCC6-24-11cr Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Month Michael Carmen Sciandra 9:05 P_{M} June 19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Prince George's Mitchellville 8. Date of Birth
(Month, Day, Ye
August 3. 9. Birthplace (State or Foreign Country) Logan, West Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 ፟ M 2 ☐ F Hours Months 207-01-9982 94 Director Yrs. 916 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Prince George's Hyattsville 1 X Yes 2 No 10f. Zip Code 20784 10e. Street and Number Stanton 6711 Staton Road 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working District of Columbia al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Government Supervisor permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the Once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Sciandra Santa Macaluso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Sciandra / Son 6888 Riverdale Road, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crematory 6/25/2011 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAY RUSINS Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Proysiciano ATHRUSC CArniousslan disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to or as a consiguence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 🗆 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Ce Lifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Chick Medical Examination on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Continuous To the best of my knowledge death occurred at the time, date and place, and due to the national To the best of my knowledge death occurred at the time, date and place, and due to the national of the national stated. within 2 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) 06-10-2011 05 2261 Name and address of person who completed cause of death (Item 23a) (Type, Print) CR 5

State Registrar JUN 2 1 2011

ak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:20P M Odessa Sloan Evone 2011 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George's 6701 Longridge Dr. Lanham 5. Social Security Number 8. Date of Birth (Month, Day, 1 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours 69 **Director** 231-54-0112 April 1942 Virginia Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Lanham Prince George's 1 X Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 6701 Longridge Dr. 20706 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 k No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider should be filed with h and Mental Hygien 7 is marked other th Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Campbell Rosie Ashton Matthew I and 2 should be I Health and Me Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Longridge Dr. John D. Sloan - Husband Lanham, Md permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory 6/20/2011 Brentwood, Md 21. Signature of Funger 13 e Licensee. 22. Name and Address of Facility Fort Lincoln Funeral Home Heta lances 3401 Bladensburg Rd Brentwood, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Izheimers disease or condition 4ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or iinjury that initiated events southing in death), least Due to (or as a consequence of). Examir sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the detached 9 Unknown 9 Unknown P.O. signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe ate Yes 2 XN 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural iniury 5 Pending s after death. Accident
Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral (Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 6/16/2011 D 37934

State Registrar 7500 Greenway Center Dire Greenbelt Md 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trifoglio, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06 Earl I. Skinner 9:35 PM 2011 14 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Prince Georges Hospital Cheverly Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 □ F 577-58-1516 69773777944 67 Yrs Director Washington, DC Usual Residence of Decedent 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director Prince Georges 28a-f Hyattsville MD 1 Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 5416 Kenilworth Avenue 20737 **USA** permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 Specify:Black If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private h and Mental Hygien 7 is marked other t traumatic event, th 12th Janitorial Engineer Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Toyer Skinner Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Emerson St, Hyattsville, MD 20781 Marie Calhoun Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 06/20/2011 Riverdale, MD 4 Donation 5 Other (Specify) Riverdale Park Crem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bianchi 814 Upshur StNW WashingtonDC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ hemorris disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions cause. Enter Underlying Division of Vital Records, P.O. Box 68760 Exami Cause (Disease or iinjury is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Markettin 1 Yes 2 No 3 Probably 4 Unknown Coagnio pathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate I Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital DR. Cheverly Md 20785

Registrar

State

31. Date filed (Month, Day, Year)

JUN 2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend#30 Per HD State of Maryland / Department of Health State Registrar6/16/2011 AACO HEALTH CM ertificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 14, June 20¹⁹1 11:30 AM Daniel Crawford Tippett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2503 Tudo Ct. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Country) C Days Hours May 13 244-42-7884 1 🔀 M 2 🗆 F 77 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No Anne Arundel MD Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 2503 Tudo Ct U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Ko
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Korea Specify: Completed 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natum injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Glennie Tippett Birdie Orene Kinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Imperial Square Odenton, MD 21113 Pamela Wright (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/16/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Road Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury Culo and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed upleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy perform After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 201

State Registrar

2123

JUN 1 6 2011

Michael Redding

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Redidman MD 129 Lubano Drive, Suite 100, Annapolis,

129 Lucal Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Dep	partment of Health and Nertificate of Death		ene OII	21236
ń			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		Robert Edward Winder, Sr.		June 08		9:45 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			8010 Levin Dashiell Road	Hebron If Under 1 Year If Under 24 Hrs.	0.0(5::::	Wicomio	
b	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 84 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Oct. 22,	1926 9 Bir	thplace (State or Foreign ountry) MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation			10d. Inside City Limits
	Mary	ō	MD Wicomico Hebro	n			1 ☐ Yes 2 ☒ No
	1 the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What C	ountry?
	h with	a D	8010 Levin Dashiell Road	21830		USA	
	dear dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am- Black, Whi	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f ehow any follury or other treumatic event, the Maryland Exerting runs it is invitible at an angle.	by Fu	1 Never Married 20 Married 1 Never Married 20 Married 1 Never Married 20 Married 1 Never N	1 ☐ Yes 2X No Specify:	,,	Specify: B	
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7	giene giene	Com		ical Therapist Ass	t.	Deer's He	ead Center
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
<u>X</u>	Men Marke Matic	ပု	James Winder	Emma Hea			
Z Z	12 sh h and 7 is m treum			ling Address <i>(Street and Number or Rur</i> 0 Levin Dashiell R			
a)	1 and Healt em 2		20a. Method of Disposition 20b. Place of Disp	position (Name of		c. Location - City or	
2	ages ant of it: If it y or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr	ematory or other place)			
Baitimore, Maryland 21215-0036	nit. Pertme			Memory Gardens June . 22. Name and Address of Facility C	alisbury,		
ñ	Deperment of the perment f the permet of th		Hatricia U. Solley	Jollev Memorial Ch			
			23a. Part1. Enter the disease, or complications! at caused the death. Do not e shock, or heart failure. List only one cause are all line.				Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	CANCER			Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Exammer	L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	led nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury				
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XO2	eath certific ettending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of de	•
D	law requires that the death certificate be executed es been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Me		Other (specify)		Month	Day Year
Ţ.	res that the de signed by the e be detached		Part II. Other significant conditions contributing to death but not resulting in the	underhijne eques awas in Part I	23a Did tohar	cco use contribute t	o the cause of death?
Vital Records,	signe d be	d by	CAPD	underlying cause given in Fact.			robably 4 Honknown
Ö	w require been si should t	ete	LING CA		24a. Was an		utaney findings available
ě	0 5 6	Completed			autopsy performe	prior to death?	utopsy findings available completion of cause of
<u>a</u>	tician: Th certificate rector, pag	e Cc	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 €	1	s 2 🗆 No
<u> </u>	Physician: rthis certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Others	ome 5 Alesidence	ce 6 TOther (Spe	ecify)
10 [ding Ph		27. Mannar of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		,
	Attending r death. ector: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
UIVISION	- 0 - C	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - AI home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,		ural Route Number,
ב	pital o		20a Cartillar (F) Obesit and Physician T-				
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medicai	29a. Certifier (Check only one) (Check only one)	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caused at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	roth within Foth	Me	29b signature and the of certifier	29c. License number	290	. Date signed (Mon	n. Day. Year)
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/	401		30. Name and address of person who completed cause of death (Item 23a) (Type	a. Print)	0.4		CM CRUM
/	VH		MITCHER CITTERIAN 200, 314	13 WINTERNAM	AK' 200	163	JAN TO
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	B. Print) C3 WINTERAME			Sizol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 1 237

		1- For State Registrar	Cert	tificate of	Death			Reg. I	No.		
Physicia		Decedent's Name (First, Middle,Last)				-		Date of Death Month Da	y Year		3. Time of Death
ledical Exami	ner	DETO Wayric Zombio						une 12, 201			0915 hrs
		4a. Facility Name (if not institution, give str Meritus Medical Center	eet and number)	4	b. City, Town, o		of Death		4c. County of Washingt		
Funeral		Social Security Number	7. Age (In yrs. las	st hirthday)	If Under 1 Ye		er 24Hrs. 8	Date of Birth (N			place (State or
Director		219-66-0435 ₁ X _M		Yrs.	Months Da			10/03/1	- 1	Foreign Cour	Marvland
any		Usual Residence of Decedent 10a. State 10b. County	10c City T	Town or Location							10d. Inside City Limits
≱ l	'n	Maryland Washingtor		liamspo						- 1	1 Yes 2 No
faryla 28a-f	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of Wha	t Count	ry?
ith the Maryland 23a or 28a-f sho notified at once.		16714 Sterling Rd.			21795	;			U.S.A.		
ath with tems 23	neral	11. Marital Status 1 Never Married 2 X Married	. Was Decedent Ever in U.S Armed Forces?		Decedent of H s, specify Cuba				14. Race - White,		an Indian, Black,
ifter de: 11", or i	by Fund	3 Widowed 4 Divorced If Y	Yes 2 X No es, Give Year Dates:	1 🗆	Yes 2 X N	o specify:			Specify:	Whi	te
ours a		15. Decedent's Education (Specity only h	ighest grade completed)		s Usual Occupa			done 16	b. Kind of Busi	iness/Ind	dustry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she njury or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Driver	st of working life	e. DO NOT	use retired)		Parcel	De1	ivery Co.
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21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (David Lee Zombro						Zombro			
Ould I Mer	2	19a. Informant's Name/Relationship (Type,		19b. Mailing	Address (Stre	et and Num	ber or Rural	Route Number	City or Town,	State, 2	Zip Code)
MD id 2 shoulth and no 27 is aumati		Karen M. Corun-sis					re Be	Lcamp, 1	MD 2101	L7	
Fe, s 1 am f Heal		20a. Method of Disposition 1 Burial 2 X Cremation 3 1		ace of Disposit ematory or other	ion (Name of ce er place)	emetery,	Da	te 20	c. Location - C	City or T	own, State
Page nent o		4 Donation 5 Other Specify:	Smi	_	Cremat	- 1			mithsb	— •	
Baltimore, permit. Pages I an Department of Hea Important: If itel njury or other tr		T. ignature of Funeral Service Licensee	17	22. Na 1 3	and Addres	s of Facility	Doug	as A.	Fiery F	une	ral Home
Physician	Н	23a. Part I. Enter the disease, or omplicat	ons that caused the death. I								MD 21742 Approximate Interval
/Medical		failure. List only one cause on each li	ne.	o not orkor the	o mode of dying	,, 5201 05 50	ar ar ar a a a a a a a a a a a a a a a	piratory arrost,	orioor, or ricar	`	Between Onset and Death
Examiner			tiple Injuries to (or as a consequence of):							-4	- Dedut
		Sequentially list conditions, b									
	iner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of):								
od Isit	Examiner	events resulting in death) Last Due	to (or as a consequence of):								
Sox 68760, death certificate be executed to a strending physician and a for use as the burial - transit	/Medical	d d An	MENDED								
760, ficate be exe g physician a the burial -	Med	IF FEMALE: 2	3c. If yes, outcome of pregna					T	23d. Date of de	elivery	
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- 4 ≥ 5	by Pi	Part il. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause	given in Par	rt I.				e cause of death?
8 .8 e								1 Yes 2	No 3	Probal	bly 4 🗹 Unknown
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Records, The law requir, ficate has been si	Completed							performed 1 Yes 2	? dea	ath? ✓ Yes	2 No
tal Recian: The	Be	25. Was case referred to medical examiner?			26.Plac		Check only				
bysic Ithis of Ithis		1 ✓ Yes 2 No	· · · · · · · · · · · · · · · · · · ·	R/Outpatient				me 5 Resi			
n of Vital ding Physician: After this certif funeral director,	<u></u>	1 Notural	(Month Day Year)	28b. Time of Inj 2032 hrs		ıry at Work?	leub	Describe how ject motorc			motor vehicle
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /		29a. Certifier (Check only 1 Certifying Physician:	To the best of my knowledge	, death occurre			ce, and due	to the cause(s)	and manner a	s stated	
To the Hos within 24 h To the Fur completely	Medical	and	the basis of examination and manner stated.	//or investigatio			zurred at the				
	2	29b. Signature and title of certifier		~	29c. Licens		DOME		d. Date signed		n, Day, Year)
		Thodore Mi	Kind JR.	mil	O.C.	M.E.		Jı	ine 13, 201	11	
		 Name and address of person who comp Theodore M. King, Jr., MD. 	leted cause of death (Item 2: Assistant Medical Ex		00 W Baltin	nore Stre	et Baltin	nore, MD 21	223		
St:	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature		J TV. Daill		or, Daitil	TOTO, IND Z			
Regist		1111 05 2011	The same of	hour	Les .						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year EDUARDO **Physician** ALCIVAR ANDRETTA 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Eciliador 1 **X** M 2 □ F 68 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified at 1 X Yes 2 □ No Guayaguil 10. Zip-Code Director 28a-f GLAVAS 10e. Street and Number 10g. Citizen of What Country? ō KCHAdor Items 23a CHIMBORAZO 3310 Y AZWAY Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ᠕0 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 'natural", or 1XYes 2 No 2 Specify: White 3 Widowed 4 Divorced Ecudorian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4 or 5+) HUSDI tal Doctor is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eduardo 1812 Manhatton, NY 10013 88 if Item 27 INAR Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of important: If it any injury or c 1 🗌 Buriai 2 🔣 Cremation 3 Removal from State HANOVER July 3,2011 4 Donation 5 Other (Specify) 21. Signature of heral Service Lice Charles L. Steres F.H. INC. any in 1501 E. Fort Avenue Approximate Interval Between Onset and Death ter the diseas corporations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. L o e cause on each line Immediate Cause (First disease or condition resulting in deal.) HYPOXIA Tue to (or as a consequence of): **Physician** /Medical Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed BILATERAL HENDPNEUMOTHORAX bunial-tra and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No Yes P.0. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Se. 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 1 KInpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 🗌 DOA 5 Residence 6 Other (Specify) မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 X Natural 2 🗌 No 1 🗌 Yes 2 Accident Lirector 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOU1 Dilarva Cettomou, MD JULY 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

4940 Eastern Avenue, Baltimore, MD, 21224

CETTOMAI, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Of IVI	aryland / Depa <i>Cer</i>	artment of Hi tificate of D			ene eg. No. 2 N I	1	21220
Physicia	an/	1. Decedent's Name (First, Middle, Last)	, T			2. Date of Death Month	Day Ye	ar (3. Time of Death
Physicia Medi	cal		ich, Jr.		the saf Danth	June 30	2011		9:58a M
Exami	ner	4a. Facility Name (if not institution, give street and number) Carroll Hospital Center		4b. City, Town, or L			4c. County of E	roll	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 G F 7. Ag	ne (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 5	year) 1940	Birthplac Country)	ce (State or Foreign MA
/land f show ed at	tor	Usual Residence of Decedent	10c. City, Town or Low					10d.	. Inside City Limits
n the Mary a or 28a- be notifie	Funeral Director	10e. Street and Number	Westminst	10f. Zip Code		1	0g. Citizen of Wha	: Country	1 Yes 2 X No
ath with ms 23 must	2204 Timothy Drive 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - An Black, Wh								Indian
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	If Yes, specify Cuban		Rican, etc.)		Vhite, etc.	
Maryland 21215-0036 12 should be filed within 72 hours after ath and Mental Hygiene. 27 is marked other than "natural", o r traumatic event, the Medical Exam	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No No No No No No No								
ygiene ygiene her th	Be Co	+8	· 1	ege profe				ucat	
and antal H ced ot c ever	To B	17. Father's Name (First, Middle, Last) George Samuel Alspach, Sr.			18. Mother's Name Carolyn S	, ,	,		
aryl nould be not Me s mark		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street ar				, Zip Coa	le)
nd 2 sh ealth a m 27 is		Mrs. Margaret C. Alspach(sp		Timothy 1	Dr., West				
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe.		20a. Method of Disposition 1 ☐ Burial 2 【**X*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place ty Cremat:) [20c. Location - Cit Sykesvill	•	
Balt permit. Departi Import any inji		21. Signature of Funeral Service Licensee Para Standard Service		2. Name and Address				e & C	hape1
₽nysician/		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	d the death. Do not entre. Respira a consequence of):			r respiratory arre	st,	In	pproximate iterval Between inset and Death
Examiner			aleral 1	Duemoni	'Li				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of.						
f60 sate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c.	a consequence of):					+	
/60 icate be physici s the bu	ledical	d							
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed st death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	-		23d. Date o	f delivery Da	
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Division of Vital Records, tal or Attending Physician: The law requires as after death. al Director. After this certificate has been signed in by the funeral director, page 2 should be	Completed	Cancer of Bladde	V			24a. Was al autops perforr	ned? dear	h?	findings available pletion of cause of
ital Ke(iician: The la certificate ha	Be Co	25. Was case referred to medical		26. Pla	ce of Death (Check	1 Tes	No 1	Yes 2	□ No
Vita nysicia nis cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpar	tient 2 🗆 ER/Outpatie	nt 3 DOA Other	4 Nursing Ho	me 5 🗆 Reside	nce 6 Other (5	Specify)	
on of Vital Inding Physician: The The This certificate the funeral director, is	Certificate:	27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident Investigation	ury 28b. Time of injury	work?		28d. Describe ho	w injury occurred		
JIVISIC il or Atte safter de l'Directo d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number o , State)	r Rural Ro	oute Number,
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the t.	Medical	29a. Certifier (Check 2 Medical Examiner: On the bast of only one) 3 Certifying Nurse Practioner: To the	examination and/or inves	stigation, in my opinior	n, death occurred at	the time, date an	d place, and due to	the cause	
To the within To the comp	2	29b. Signature and title of certifler	eut	29c. License			9d. Date signed (M	onth, Day	
0 V		30. Name includes of person who completed cause of	death (Item 23a) (Type, I	Print) 447, B	AST HA	IN ST	REET	WEST	MINSTER.
Sta Regist		31. Date filed (Month, Day, Year) JUL 06 2011 Service 32. Regist	ar's Signature						

ALSPACH GEDRGE.

11-04795 Jennifer Ann Angles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 1 2 2 4 0

		1- For State Cer	tificate of	f Death	Reg. N	No.			
Physicia Medical Exami	ın/ ner	1. Decedent's Name (First, Middle, Last)	Mennifer Ann Anales						
		4a. Facility Name (if not institution, give street and number) 306 Cedar Run Place Apt. H		4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore Cour	nty		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la		If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (N	/M/DD/YYYY) 9. Birth Foreign			
Director	ŀ	Usual Residence of Decedent	Yrs	S	Muy 16	,19811 000	MD		
nd show any ace.	٦		Town or Locat	SVIL			10d. Inside City Limits 1 Yes 2 No		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	14	10f. Zip Code	10g. (Citizen of What Coun	try?		
th with t tems 23a	1	11. Marital Status 1 Never Married 2 Married Armed Forces?		as Decedent of Hispanic Origin? (Sp res, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,		
er.	by Fu	3 Widowed 4 Divorced If Yes 2 No If Yes, Give Year or Dates:		Yes 2 No specify:		Specify: Wh	iti		
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		nt's Usual Occupation (Give kind of w nost of working life. DO NOT use retir		b. Kind of Business/Ir	ndustry		
0036 within 7 jene.	Completed		Cust	odial Staff	(First, Middle, Maid	HOSDIT	al		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be C	17. Father's Name (First, Middle, Last)		Seus	e Ana	Allen	,		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. Sant: Hitem 27 is marked other than "natural or other traumatic event, the Medical Examin	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street and Number or R	ural Route Number	City or Town, State,	Zip Code)		
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	i):						
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00 m	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg	2 Fe	etal death 3 Ectopic pregna		23d. Date of delivery Month D	ay Year		
Box 687 he death certific the attending I	Physicia	1 Yes 2 No 9 Unknown Pregnant at time of de	ath 5 O	ther (Specify)					
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Division To the Hoopital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a and manner stated.							
F F F S	Me	29b. Signature and title of certifier		29c. License number O.C.M.E.		od, Date signed (Monume 28, 2011	th, Day, Year)		
		30. Name and address of person who completed cause of death (Item	23a)	J.O.IVI.E.					
5		Victor Weedn MD JD Assistant Medical Examin	ner 900 V	V. Baltimore Street, Baltimo	re, MD 21223				
St Regis	ate trar		1.	all					
DHMH 17 Rev 1/2	001	OGME	ORIGINA	AL					

		Please T State Amend Items Registrar	ype or Print i	n Black Ir #17perFH land / Depa	ndelible In	k. Ensure 8/2011, Ws lealth and	All Copie Mental Hy	s Are Legib	le.
	_	State Registrar Amend Items	25,27,28a-	f per me Cei	, g918,08/ tificate of L	02/2011d Death	lhb	Reg. N201	1 21241
Physicia Medic		1. Decedent's Name (First, Middle, Last) James W. And	erson Sr.				2. Date of De Month	B Day 3 o Ye	3. Time of Death
Examin		4a. Facility Name (if not institution, give str SINAI HOSPITAL	- 0	TIMORE	4b. City, Town, o	r Location of Death	UTY	4c. County of I	Death
Funeral Director		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	1 th 952	Birthplace (State or Foreign Country) MD
	ř	Usual Residence of Decedent 10a. State 10b. County		. City, Town or Lo	cation				10d. Inside City Limits
Marylar 28a-f s notified	Directo	MD Baltim	ore	Esse					1 Tyes 2 XNo
s 23a or	Funeral Director	10e. Street and Number 401 Torner Road	đ		10f. Zip Code 21 2	221		10g. Citizen of Wha	it Country?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Xoivorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 	I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 K No		pecify Yes or No- o Rican, etc.)	Biolon, i	American Indian, White, etc. White
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permit. P Departm Importar any injur once.		21. Signature of Funeral Service Licensee Patrick Per	per DV		2. Name and Addre	ss of Facility 3 (00 Mace	e Ave. Ba	alto. MD
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CO 7	I = I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ALCOHOL INTOXICATION Due to (or as a consequence of): C. Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINED C. C. Due to (or as a consequence of):							
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Physician: r this certifica rral director, p	To Be	evaminer?	spital:	2 ☐ ER/Outpatie	Oth	lace of Death (Che er: 4 Nursing F		idence 6 Other (Specify)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury FOUND Pay, Yea 06/25/201	28b. Time of FOUND	worl		28d. Describe Subject bever		alcoholic
or Atter after des Director in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)		1.00	28f. Location (City or To	Street and Number of wn, State) 1709	r Rural Route Number, Edgewood Rd
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o the Herithin 24 or the Fu	Med	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse I				e time, date and pl			
FSFÖ		▶ Shashank	Creory			5-000	3	06/30	
		30. Name and address of person who com SHASHANK C	ARG, MB	BS, SI		SPITAL	of B	ALTIMO	RE.
Stat Registra		31. Date filed (Month, Day, Year) JUL 0 6 2011	32. Registrar's S	gnature					

Fay ENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\underline{28}^{\text{Day}}$ Physician/ Blackert, Jr. J. Month June 2011 12:58p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glenwood 2555 McKendree Road Howard Social Security Number 8. Date of Birth (Month, Day, Oct 24. 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 → M 2 □ F **Director** 218-44-4116 65 Yrs. 0ct MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director MD Howard G1enwood 1 ☐ Yes 2 🛣 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21738 USA 2555 McKendree Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ю Completed by 1 Never Married 2 X Married ^{2 □}No Vietn**4**m 1 Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) agriculture research agronomist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Angela M. Cavanaugh William J. Blackert Sr. and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2555 McKendree Rd., Glenwood, MD 21738 . Page 1 and 2 sl tment of Health a tant: If item 27 is Mrs. Elizabeth Blackert (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 7-1-11 Glenwood, MD Oak Grove Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oi) Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred in 24 hours after deau...
the Funeral Director: Aft 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

State

5540 TOV DAKS

30. Name and address of person was completed cause of death (Item 23a) (Type, Print) JACKSON MB

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 0 R15 BAKER 358 M BJL 201 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** Town, or Location of Death 4c. County of Death dall Baltimore uture OWN Social Security Number 6. Şex Age (In vrs. last birthday) If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 219.26.559 1 🗆 M 2 🕱 F Month Pay MD Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore MD Baltimore 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a Completed by Funeral 21244 Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Black Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Mankand 19th grade habilitation Merapist years Be 17. Father's Name (Birst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph tt. Cashen Marie aylor 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Baker Husbana Baltimore IVCle) Jaywood 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 081 4 ☐ Donation 5 ☐ Other (Specify) 201 Owings Mills, MD 21. Signature of Funeral Service Licensee C. Greene Fluerap services Vaughn Kandallstown MD 21133 KONd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a dardiac or respiratory arrest shock, or heart filture. List only one cause on each line. Approximate Interval Between Immediate Caus (Fi al disease or condition resulting in death) Onset and Death Physician - OIME CAMEEU Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): the attending physician and thed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 g detached 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes cate has been sig page 2 should b 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 14 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred the Hospital or Attending 5 Pending ✓ Natural injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier S 29c. License number 29d. Date signed (Month, Day, Year) · RAS. M. O 2011 5 P43462 J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K S old correda # 501 15 - wotillohow -32. Registrar's Signature State Registrar

11-04934 George Bryant

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 21244

		Registrar Certificate of Death			g. No
Physici Medical Exam		1. Decedent's Name (First, Middle, Last) GEORGE BRYANT		2. Date of Death Month July 2, 201	Day Year 0333 hm
		4a. Facility Name (if not institution, give street and number) 4b. City, Tov Johns Hopkins Bayview Medical Center Baltimo	wn, or Location of Death ore		4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24Hrs Days Hours Min	٠,	(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		249 - 29 - 4√90 1⊠M 2□F 36 Yrs. Months Usual Residence of Decedent		01/30/	1975 Country) M.D.
w any		10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
uryland Sa-f show at once.	Director	MD BAUTIMORE 10e. Street and Number 10f. Zip Co		100	1 X Yes 2 No
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	i Dire	2136 AIKEN STREET 21	218		USA
eath with	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
s after d ral", or lincr m	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:			Specify: BLACK
.7		Elementary/Secondary (0-12) College (1-4 or 5+)	ng life. DO NOT use reti		16b. Kind of Business/Industry
15-0036 filed within 72 I Hygiene. ed other than " t, the Medical)	Completed	17. Father's Name (First, Middle, Last)		/Fig. A Middle No.	TRANSPORTATION
21215- uld be filed Mental Hyg marked otl	Be		SHIRLE		VEMAN er, City or Town, State, Zip Code)
O gg Pr Pr	70				
		20a. Method of Disposition 20b. Place of Disposition (Name			2E, MD . 21218 20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Dognation 5 Other Specify: ARBUTUS CEME 21. Significture of Fureral Service Licensee 22. Name and Ad	TERY 7/8	8/11	BATIMOLE, MD REENE FUNERAL SUS
Bal permi Depar Impo injur		22. Name and Ad 22. Name and Ad 22. Name and Ad 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of death.	lores of Facility V AT	иенн <i>с</i> я · Вачто	MD. 21212
Physician		failure. List only one cause on each line.	lying, such as cardiac o	r respiratory arres	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):			Death
	5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
1/2	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		=	
be executed cian and rial - transit		d.			
	n/Medical	UNPENDED AMENDED			
18760, riffcate bing physical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ncy	23d. Date of delivery Month Day Year
8 E S E S	Physicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify,)		
	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.		acco use contribute to the cause of death?
IS, P.C quires that en signed uld be deta	ted b			1 Yes	2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available
COTC law re has be	Completed			autopsy	prior to completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical 26.1		1 ✓ Yes 2	No 1 ✓ Yes 2 No
Of Vital g Physician:	o Be	examiner? [Hospital: 4] Invasions 2 4 50(0.4445) 4 0 0 000	Place of Death (Check of	, ,	esidence 6 Other:
		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c (Month, pay, Year)	: Injury at Work?	28d. Describe how Subject was s	w injury occurred
Division tal or Attendi rs after death.	ertification	2 Accident Investigation 280 Place of Injury. At home form street feature of the control of the	Yes 2 V No		eet and Number or Rural Route Number, City
Division pital or Attent ours after death neral Director:		4 ₩ Homicide determined (Specify) Bar/tavern		or Town, Stat	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical (29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my open content of the content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation, in my open content of the basis of examination and/or investigation.	ne, date and place, and pinion, death occurred a	due to the cause(s	s) and manner as stated. d place, and due to the cause(s)
To Viti	Med	and manner stated.	icense number		29d. Date signed (Month, Day, Year)
		Punch Forthall, MD	D.C.M.E.		July 2, 2011
4		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltir	more Street Baltir	more MD 212	23
	ate	31 Date filed (Mooth, Day Year) 32 Registrat's Signature			
Regist	rar	JUL 0 6 2011 Cener B. Jakes			

Physician /Medical Examiner

Funeral Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at the

Director

Funeral

filed within 72 hours after death with the Maryland . Hygiene. Pages 1 and 2 should be rent of Health and Mental permit. Pages 1 and 2 shoul Department of Health and MI Important; If Item 27 is marl any Injury or other traumati

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed and burial-trar attending physician use for the page 2 funeral director, this After t or Attending after death Director: filled in by

Division or Vital Records, P.O. Box 68760,

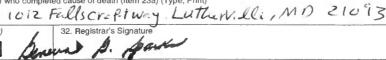
21245 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:40 PM -03-2011 7 0 batte 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Mondy Char 100 00 If Under 24 Hrs. 8. Date of Birth Sept. 30 ear.) 923 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 233-36-9619 Days 87 1 □ M 2 XF WVA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 Charles Street USA 7001 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Franklin Square Elementary/Secondary (0-12) College (1-4or 5+) Aid Hospital 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Tittle Berta Mae ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24317 Canal Drive Millsboro DE 19966 Cheryl Kraft /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 7/6/11 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the do th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition emen' disease or condition Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▶ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 SNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asadi,

31. Date filed (Month, Day, Year)

1 24 hours a Hospital

To the

HCC54424

07-05-11

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Der:nis 20 Î Î E1mo 2 Bryant 0419 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 240 Candle Light Lane Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 OV 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Hours 8-10-1929 444-28-8759 Director OK Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? be Funeral rral", or items 23a Examiner must b 240 Candle Light Lane 21061 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: white "natural", 3 Widowed 4 Divorced Completed Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Warehouse Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ant of Health and Mental Hit: If item 27 is marked ot y or other traumatic ever ည Dillard Bryant Gracie Colwel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy L. Bryant Cole/daughter 10555 Rather Rd Knoxville TN 37931 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot X Burial 2 Cremation 3 Removal from State 7/6/11 Loudon Park Cemetery Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Signature M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of bing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Inset and Deat Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 Residence 6 \(\triangle \) Other (Specify) 1 Yes ျှ 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 DOA Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and itle of certifie 4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death nth Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Northwest Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Country) MD Min 1/19nth 22 - Year)1 1 M 2X X 212-76-9397 49 Director Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director XX 1 Yes 2 No or 28a-f s Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a with USA 21230 625 Archer Street ed other than "natural", or items event, the Medical Examiner mu death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examiral. 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Specify: American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Andre Janitorial Elementary/Seconday (0-12) 12th Grade 2yrs. Service Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Beads Geraldine Brady Lemmie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Penrose Avenue Baltimore, MD. 21223 Celita Downing-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State OnSite Cremation 07-05-11 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. Signature of Funeral Service Licenses 22. Name and Address of Facility Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or conshock, or heart failure. List only reations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin; Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): ng physician ar as the burial-to resulting in death) Last Completed by Physician/Medical Chivision of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day ģ Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably Dinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy certificate 1 Yes 2 No 2 No Yes Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 2 Accident (Month, Day, Year) 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature

Registrar
DHMH 17 Rev 7/2009

State

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dionne 8:30A Brooks Medical **TUO**? Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Randallstown Northwest Seasons Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 - M 2X-XF Days Hours Min 10-18-59 ^tMD 216-72-4615 51 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Funeral Director XX Yes 2 No NA Baltimore MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be i USA 21217 1949 Ridgehill Avenue 14. Race - American Indian,
Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner þ 1 X Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: American Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Seconday (0-12) 10th Grade Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Home maker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) Mary Katherine Smith 17. Father's Name (First, Middle, Last) ည Brooks Jerome Bernard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1949\ Ridgehill\ Avenue\ Baltimore, MD.$ 19a. Informant's Name/Relationship (Type, Print) Russell Shipman-Fiance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 07-07-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) OnSite Cremation 22. Name and Address of Facility Wylie Funeral Home P.A. Signature of Funeral Service Lice ee 638 N. Gilmor Street Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only the cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Lymphoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 2 No 1 Yes 2 L 9 Unknown cate has been signed by page 2 should be detaci Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital. ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work?
1 Yes 2 No 5 Pending s after death. 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

24 hours Medical 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MS (Maphine M.D.) 29d. Date signed (Month, Day, Year) 6/30/11 00057465 Baltimore MD 21209. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203 N.S. Rajapakse, M.D. 2835 Smith 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BULLION Month Year NHOL -45P M First TULY 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE GRVINGTON BALTI MORE NA5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hours Min. 05-25-43 214-40-9808 68 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21217 1000 N. Gilmor Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes XX No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give Year or Dates Specify: Caucasion 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
/th Grade Entrepreneur varies jobs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bullion Dorothy Lorine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8674 N. Heartland Way Fresno, CA 93720 Joan Marie Boggs-Daughter 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot On Site Cremation 07-05-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Dert 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List rily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alherosclerotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the s should be detached 1 Yes 2 L q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4.12 Nursing Home 5 - Residence 6 - Other (Specify) Hospital 2. No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 15503

Registrar

State

DOLPHINST BALTIMORE MN 2/217

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

0 6 2011

NI MARCOM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 2125

		1- For State Registrar Certific	ate of Death	Reg. N	0.	
Physic		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day		3. Time of Death
Medical Exam	iner	Kenneth John Bellin		July 3, 2011		0116 hrs
		4a. Facility Name (if not institution, give street and number) 308 High Falcon Road	4b. City, Town, or Location of Death Reisterstown	h	4c. County of Death Baltimore Cou	1
				Doto of Birth /All		
Funeral Director		392-52-3493 1XXM 2□F 47	thday) If Under 1 Year If Under 24Hr Months Days Hours Mir Yrs.	April 11	,196 Co	the large (State of in number) MD
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.			isterstown			1 Yes XX No
Maryland 28a-f show d at once.	cto	10e. Street and Number	10f. Zip Code	10a. C	Citizen of What Cour	
or 2	Director	308 High Falcon Rd.	21136		U.S.A	
with the Maryland ms 23a or 28a-f sho be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	
or iten	Funeral	Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after all, o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 🔭 No specify:		Specify: W	nite
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner			Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use ret	work done 16b	. Kind of Business/li	ndustry
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5-00; led with Hygiene other ti	Completed	17. Father's Name (First, Middle, Last)	Bartender 18 Mother's Name	e (First, Middle, Maide	Beverage	2
D 21215-0036 should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland 71 smarked other than "uatural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	Be C	John Ernest Bellin		Ann Sim	· ·	
21215 ould be fill I Mental H	2		b. Mailing Address (Street and Number or			Zip Code)
and 2 shou calth and N			15 W. Shenandoah S	t. Ova Va	11ey, AZ	85737
ore, MD 2 es 1 and 2 shou of Health and P If item 27 is n her traumatic		20a. Method of Disposition 20b. Place of Cremal Surial 2XX Cremation 3 Removal from State	of Disposition (Name of cemetery, ory or other place)	Date 20d	c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of Hc Important: If its injury or other tingers.		4 Donation 5 Other Specify:	ory or other place) All Faiths Atory & Chapel 7/	6/11 M	<u> </u>	er. MD
Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funeral Service Licenses	22. Name and Address of Facility EC	khardt Fu	ineral Cl	napel P.A.
		Mishal James	11605 Reistersto	wn Rd. Ow	inas Mil	Lls, MD 211
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line. MUITIPIE drug	t enter the mode of dying, such as cardiac of toxicity involving	ethanol, n	hock, or heart Arcotic	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ne),Topiramate Amit	riptyline,		Death
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760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy		2	3d. Date of delivery	
ox 68 eath certifu attending	ia	23b, was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death		ancy	Month D	ay Year
Box 68' e death certifi the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			- 1
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ords v requ s been	Completed			24a. Was an autopsy		topsy findings available ompletion of cause of
Hecc The lay ate ha	티	-		performed? 1 ✓ Yes 2		
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical	26 Place of Death (Check	only one)		
of Vital Records, ng Physician: The law requir After this certificate has been s meral director, page 2 should I	TO E	1 V 1es 2 140	utpatient 3 DOA Other Nursin	ng Home 5 Resid	dence 6 🗸 Other:	Scene
n of ding Ph		(Month, Day, Year)	Time of Injury 28c. Injury at Work?	28d. Describe how in		al and duman
Sior Attend death ctor:	atic	2 Accident Investigation fd 7-3-11 fd	1:00 alli			ol and drugs
Division tal or Attendi rs after death. al Director: A	Certification:	determined (Specify) found at	arm, street, factory, office building, etc.	or Town, State)	308 High	Falcon Rd.
Cospital to the control of the contr		29a. Certifier		Keisterst	own,MD.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or i				
To with To cont	Mec	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Mon	th, Day, Year)
		The standing	O.C.M.E.	Ju	ly 3, 2011	
_		30. Name and address of person who completed cause of death (Item 23a)				
		Victor Weedn MD JD Assistant Medical Examiner	900 W. Baltimore Street, Baltimo	ore, MD 21223		
		31. Date filed (Month, Day, Year) 7. Registrar's Signature	back			
Regis	trar	JUL 0 6 2011 Denera B. A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death Time of Death Month Jun. Physician/ 1413 Medical 4b. City, Town, or Location of Balffred Co. 4a. Facility Name (if not institution, or Location of Death 4c. County of Death Examiner University of Maryland Medical Centa If Under 1 Year If Under Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. (Month, Day, Year) 2-13-1952 213-50-9073 59 **Director** Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits the Maryland notified at 10c. City, Town or Location Director Carroll 28a-f MD Westminster 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be with 1 Funeral 348 Hook Rd. 21157 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Security Security Guard 12 permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary E. Kolbe Charles W. Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gaile S. Bailey - wife 348 Hook Rd., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 7-6-11 Shipley, MD Zion UM Cem. 4 Donation 5 Other (Specify) ture Juneral Service Gensee 22. Name and Address of FacilityFletcher Funeral Home 254 21157 Ε. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TU400(Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Fix to ME/e^{i} Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death been signed by the s should be detached t Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy Hospital or Attending Physician: The After this certificate 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year,

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM 201 B1_{um} une Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A SAINT AGNES TIMORE 8. Date of Birth (Month, Day, Year) Aug. 20, 1927 9. Birthplace (State or Foreign Social Security Number e (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Hours 1 🗆 M 2 🛣 F Mary Tand Director 216-20-7226 83 Aug. Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and it ifem 275 is marked other than "natural", or items 23a or 28a-f sho and tife than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Maryland</u> N/A <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21230 U.S.A. 108 East Clement Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 🛮 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Box Factory 12 Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Young Lillian Reedy Samue1 19a. Informant's Name/Relationship (Type, Print)
(Personal)
Milan Miculinic(Representative) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Bertram Circle Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 07/07/2011 Brooklyn Park, Maryland 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Dent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Atheroscieratic cardiovascular MKNOWN disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a nonsequence of) if a y, leading to himediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed F.brillation Atrial 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No] Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 🗌 Yes 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier elleurs D0058141 endio 301 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Caton

Avenue

Baltimore, MD

900 S.

Williams

Wendie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUI Y 01 20^{Year} MARCIA 01:00P M BRENNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARDEN COURTS BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months 107207 1932 1 🗆 M 2 👿 F 212-30-8547 78 MD **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD BALTIMORE REISTERSTOWN 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 0 10g, Citizen of What Country? "natural", or items 23a Funeral USA 113 DANBURY ROAD 21136 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **STENOGRAPHER** GOVERNMENT Be permit. Page 1 and 2 should be filec.
Department of Health and Mental Hy, Important: If item 27 is markany injury or other to once. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **AARON EXLER** LENA COHEN D. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD BRENNER/HUSBAND 113 DANBURY ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 № Burial 2 □ Cremation 3 □ Removal from State BALTIMÓRE HÉBREW CÉM. 07/03/2011 REISTERSTOWN, MD Donation 5 Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific D0061199 I 201

Registrar
DHMH 17 Rev 7/2009

State

N Charles

Suite 4/05 Touson MO 2/204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Jasin Blac

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04:50P PHILIP BARON JUNE 30 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALT IMORE 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country) RUSSIA 1 **X** M 2 □ F Days Hours Min 04/2<u>4/1919</u> Yrs Director 218-10-3497 92 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director MD **BALTIMORE** OWINGS MILLS 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21117 USA 3440 ASSOCIATED WAY items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, the Medical Examiner Black, White, etc. 5 ģ 1 Never Married 2 Married 2 **X X**No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: WHITE Specify 'natural" Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ **EXECUTIVE** CONSTRUCTION of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MORRIS BARON **FANNIE FELDMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7913 IVY LANE, PIKESVILLE, MD 21208 ANITA BARON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Wy Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/2011 BALTIMORE MD22. Name and Address of Facility SOL_LEVINSON 21. Signature of Funeral So 8900 REISTERSTOWN ROAD, **2120**8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ METASTATIC BLADDER CARCINOM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to finmenate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death ģ Division of Vital Records, FIBRILLATION 1 Yes 2 No 3 Probably 4 7 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed? prior to completion of cause of death? 2 1 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) TOSPICE Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

JUL 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death dent's Name (First, Middle, Last) 56 AM Physician/ 2011 Medical 4b. City, or Location of Death 4c. County of Death **Examiner** Medic 8. Date of Birth (Month, Day, Year) **May 6, 1945** If Under 24 Hrs. 9. Birthplace (State or Foreign If Unde **Funeral** Months Hours MD M 2 🗆 F 66 218-44-5185 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Directo **Baltimore** 1 Yes 2 No **Baltimore City** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21223 206 Furrow St. 27 is marked other than "natural", or items traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) I Hygiene. other than " life. DO NOT use retired)

Woodworker Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F Lothia Lee Johns ၉ Glen Beverly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3622 Clarenell Rd. Baltimore, MD 21229 19a. Informant's Name/Relationship (Type, Print) Cathy Keaton Sister Health tem 27 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other to other 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Jul 05, 2011 Glen Burnie, MD Atlantic Crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Nam}Stack Fünerar Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ute of Funeral isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Deat Enter the 23a Part shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition - Physician/ Medical resulting in death) Examiner lee umonia Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death Other (specify) 2 🗌 No certificate has been signed by the rector, page 2 should be detached ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Other: မှ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Manner of Death 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No М n 24 hours after death.

Ie Funeral Director: A pleted filled in by the fu Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29c. License number 29b. Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BARRETT 7:00 AM 2011 MAURICE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2626 Thorney Dr. Churchville Harford 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1920 Maryland Months Davs Hours (Month, Day, Year) 1 M 2 □ F 90 **Director** 219-01-8794 Usual Residence of Deceden 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Churchville Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral or than "natural", or items 23a the Medical Examiner must b United States 21028 2626 Thorney Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14 Bace - American Indian .12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates. WWI 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene.

If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Stanford Paper Co. Vice-President Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madeline Lamden Charles William Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5610 Remmell Ave. Baltimore, MD 21206 Jeff Barrett /Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Jul 02 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or otl Page 1 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2011 4 Donation 5 Other (Specify) Chesapeake Crematory 22. Namered Alternatives Signature of Funeral Service Licenses Rebecca 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final curum Ph_sician/ VYSPITH GIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Years PARILINSON'S DINE MSE Sayuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine requires that the death certificate be executed ng physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 ed by the attending | detached for use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year in the past 12 months? Yes 2 No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 → No 3 □ Probably 4 □ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director; After this certificate has b page 2 s 1 \(\text{Yes} \) 2 No 1 Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

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Registrar

DHMH 17 Rev 7/2009

State

KEN WOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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SOEI 91100/80/0 Baltimore, Maryland 21215-0036 Brans, Dominice #28 b Division of Vital Records, P.O. Box 68760

		For State amend Registrar	Plea	se Ty	REND State o	Pri f M	nt in EM#1 aryland	lack perf d_/ Der	ndeji partme	nt of h	K2 F2841 9 Health and	Menta	pies I Hygi	Are Le	gible		
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Physicia Medic		1. Decedent's Name (File			ames			Bruno				2. Date Mor Jun		Day 28	2011	3. Time o	of Death M
Examin	er	4a. Facility Name (if not Shady Grov					pital		4b. Cit		Location of De	ath		4c. Count		th omery	
Funeral Director		5. Social Security Numb	- 1	6. Sex 1 ሺ M	1 2 🗆 F	7. Ag	e (In yrs. la:	st birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 H Hours M		of Birth	Year) 1931	9. Bir Co Ne	thplace (State ountry) SW York	o <i>r Foreig</i> n
nd how at	<u>_</u>	Usual Residence of Dec 10a. State 10	edent b. County				10c. City	, Town or L	ocation							10d. Inside C	
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with the 23a or ust be n	era	10e. Street and Number 8701 Slee		11ow	Lane	<u>.</u>			10f. Z	ip Code	20854		11	0g. Citizen of Unit		ountry? States	
Tand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The mary is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	11. Marital Status 1 Never Married	2 🗌 Marri	ed	Armed Fo	rces?	ver in U.S	. 13.	If Yes, sp	ecify Cuba	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes erto Rican, e	or No-	Bla	ck, Whit	erican Indian, ce, etc.	
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Page 1 arment of He ant: If iter ury or oth		20a. Method of Disposit 1 XX Burial 2 C 4 C Donation 5 C	remation		noval from	State	ce	ace of Disp emetery, cre e of	matory or	other place	m. 07/	Date 01/201	- 1	20c. Location ${\tt Silv}\epsilon$	-	Town, State	MD
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		23a. Part 1. Enter the d	isease, or o	omplicat	ions that c	ausec	the death	. Do not en			Ave., S g, such as cardi					Approxima	
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ed sit	Examiner	Sequentially list conditions, it any, leading to inmediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of the conseque					is a consequence of:)					
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		1 Live I	Birth nant a	of pregnan 2 Fetal t time of de	death 3	☐ Ectopic ☐ Other (s		v sy				ate of de		Year
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vith vith com		29b. Signature and title	of certifier	1		N	1.1)	29	c. License	number 5 13 2			od. Date signe		h, Day, Year)	
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State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ A. amfort Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Northwest Hospital Center Randal1stown Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 85 yrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Min 10/13/1925 1 🗆 M 2 🔀 214-20-3132 **Director** Md Usual Residence of Deceden 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Md. Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1601 Unit 3E Homeland Dr. 21784 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Md. State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Peter Guarino Lillian M. Lutz 19a. Informant's Name/Relationship (Type, Print) E. Ronald Comfort(Son) 24 N. Court St. Westminster, Md. 21157. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Lake View Sykesville, Md. 07/07/2011 21. Signature of Furgeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. aul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MEIMONIA disease or condition Medical resulting in death) Du to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence on. if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events 4RDH1515 Due to (or as a consequence of): ŵ resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death the g Unknown 9 Unknown P.O. | sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, E FFU SION Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes ESOPHAGEM VAR LES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsv performed' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🔲 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10GINDER 170R 31. Date filed (Month, Dav. Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month July Virginia Lorraine Cross 201 Ĭ 5:35p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carrol1 Svkesville Transitions Health Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yes 1 M 2 W Hours Director 219-12-0429 90 1920 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 No MD Sykesville Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7311 Jennifer Way 21784 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 💹 No If Yes, Give Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: white 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done of life, DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 George G. Leakins Sr. Sadie Warfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 200 Erin Way T-3, Reisterstown, MD 21136 Charles McDonald (son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Airy, MD Pine Grove Cemetery 7-6-11 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Jacquot Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscelortic Cardiovascular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed Hospital or Attending Physician: The law death? certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 1 Yes Other: Nursing Home 5 Residence 6 Other (Specify) 200 No 1 Inpatient 2 ER/Outpatient 3 DOA ြုင After this 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending 1 Yes 2 No death. ☐ Accident☐ Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiel Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check Fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 9 f certifie License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 oll bir 1AITMOOD 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Physician/ DOSAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice at Northwest Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Days Hours 0172171923 1 X M 2 - F 218-12-8750 88 **Director** Md Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1601 Unit 3E Homeland Dr. 21784 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) 10Yrs. College (1-4 or 5+) Truck Mechanic Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Howard Carder Arthur Edmund Comfort 19a. Informant's Name/Relationship (Type, Print) E. Ronald Comfort (Son) 24 N. Cort St. Westminster, Md. 21157. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/07/2011 Sykesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Fundal Service Licensee P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Medical resulting in death) Due to (or as a c sequen of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certificaleted filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Month-30^{Day} Robert Leroy Cassel1 22:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Carroll Hospital Center Westminster 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Yea ar 23, 1 1**X**□ M 2 □ F 58 Yrs Director 212-62-4797 Mar Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Carro11 Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 3303 Eckard Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lineman Utilities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Virginia Lee Fisher Robert C. Cassell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 E. Broadway St., Union Bridge, MD 21791 Ms. Sharon Lee Cassell (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State All County Cremation :7/2/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licersee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ memsmanic oancrestic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1 Yes 1 Inpatient 2 ER/Outpatient 3 s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \square Yes 2 🗌 No ieral Director: A filled in by the fi Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical ■ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

THOMAS

31. Date filed (Month, Day, Year)

JUL 0 6 2011

1731660

2911 STOWER AVENUE

7/1/2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 01^{Day} Zola Leona Collins 2011 Year 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Morningside House Parkville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 29, 1920 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F 389-14-0379 90 Director Yrs. Marquette, MI Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified at MD Baltimore Nottingham 1 Tes 2 X No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a 3557 Moultree Place 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural" 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ျှ Frank E. Lyberg Florence Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Gary Collins- Son 3557 Moultree Place, Nottingham, MD If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important, If ite any injury or ot once, \square Burial 2 f X Cremation 3 \square Removal from State Evans crematory of other Place) Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Chapel Αi Bel 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility. Evans Funeral Funeral Chapel & Cremation Services Harford Rd. Parkville, MD21234 23 Part | Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Im nediate Cause (Final disease or condition resulting in death) nset and Death Physician/ tage Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): 0/0 that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 20/0 Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 mon Month Pregnant at time of death 1 Yes 2 9 Unknown the detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed/by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy death? performed Yes 2 No **Division of Vital** funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one)

29b. Signature and Ittle of certifier

Deewe-6 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

acal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

201

Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Crouch 2-11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE St. Armes HUSPITAL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 🕱 M 2 🗆 F 79 MD Director 09/08/1931 215-28-9123 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at 1 TYPYes 2 □ No Funeral Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21230 2805 Mauldin Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 1274es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify Completed by Specify: White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant Fire Department 11 and Mental Hygies marked other 1 event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta fitem 27 is marked rother traumatic en ည Harry Edward Crouch Weisharr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald B. Crouch / Son 7964 Covington Avenue Glen Burnie, MD 21061 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 07/08/2011 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ·)~/< a MEXIMENTE INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No After this certificate has been s funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? **≱**ZiNo Division of Vital 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 | Yes 2 | 1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred r Attending F er death. 1 Natural Injury 5 Pendina To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1764307 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

A. VITREAL, MID

31. Date filed (Month, Day, Year)

JUL 0 6 2011

Cloc (trail

32. Registrar's Signature

M)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11 per spouse 6926 4/27/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1024 AM Month 2011 saw to 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Man Comey WASHNOWN MUSIKAT Mrcma Mario If Under 1 Year If Under 24 Hrs. 7. Age (in yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 X M 2 □ F Min Months Hours Mar 28 ^{Year)} 1934 Virginia Yrs Director 77 230-38-3032 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 116 Lee Avenue #402 United States 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\subseteq \) No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1953-1961 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Diverged Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Service Ranger Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (unk) Hallie Crawford (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 i Michael A. Crawford / 23521 Forest Haven Way Clarksburg, MD 20871 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/5/2011 Journey Crematory Woodbine, Maryland ^{22.} Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ye of Funeral Service Licensee 21. Signa murel MO1251 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Motosclerac Continuentilla Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Secretar tight fat our different Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): /sician a Box 68760 attending physi I for use as the b IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? signed by the atte Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Certificate: eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No M ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7547 07-01-2011 who completed cause of death (Item 23a) (Type, Print) Name and address of person WI Curoll Ne Macuna 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	or marytaire	Cen	tificate of D	Death		Reg. No.	UII	212	65	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				_	2. Date of Dea	ath Day	2011	3. Time of Do	eath M	
	Medic Examin	al	ELSIE MARGARET CUBA 4a. Facility Name (if not Institution, give street and number)				Location of Death	July	4c. Coi	unty of Death			
	-		Lorien BelAir BelAir Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth								place (State or F	oreign	
	Funeral Director		218-30-5244 1 DM 2XXF	1 M 2XXF 77 Yrs. Months 1			Hours Min.	02/09/19	34 ^(ar)	Mairy			
with the Maryland	and show I at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				1	0d. Inside City		
	Maryli 28a-f otifiec		Maryland Baltimore	Balt	imore	1		- Т			1 🗌 Yes 2	XX No	
	with the 23a or ist be n		10e. Street and Number 8823 Old Harford Road			10f. Zip Code 212	34			of What Cour SA	ntry'?		
	death items		11. Marital Status 1 Never Married 2 Married 1 Preserved 1 Preser	cedent Ever in U.S.	13. V	/as Decedent of H Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,			
036	rs after ral", or Exami		If Yes Give 1 Yes 2 MNo Specify: Specify:						ecify: W	nite			
15-0	72 hou n "natu fedical		15. Decedent's Education (Specify only highest grade complete		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of worki	n <i>g</i>	16b. Kind	of Business In	dustry		
212	within giene. ier tha t, the N		Elementary/Seconday (0-12) College	(1-4 or 5+)	Cler				Baltir	nore Cour	nty		
land	should be filed within 72 hours after death with the Maryland n and Mental Hyglene. I is marked other than "natural", or items 23a or 28a-f sho is marked other than "staminer must be notified at raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) William Heim				18. Mother's Name Elsa Ge		Maiden Sun	name)			
nore, N	and 2 shoulk Health and N em 27 is ma		19a. Informant's Name/Relationship (Type, Print) Mariano Cuba	fusband	19b. Mailin 8823 0	g Address (Street a ld Harford	and Number or Rura Road Baltim	n Route Numbe pre, Mary	r, City or Tow yland 2	vn, State, Zip (1234	Code)		
	age 1 ent of nt: If ii y or o		20a. Method of Disposition 1 XX Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)		metery, crem	sition (Name of latory or other place)	ce)	Date // 2011		tion - City or To um Maryla			
Balti	permit. P Departmo Importar any injur		21. Signature of Funeral Service Licensee Dulaney Valley Mausoleum 107/06/2011 Timonium Maryland										
ı		Г	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between										
~	Puj ician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a consequence of):										
	Examiner		Sequentially list conditions, b.	o (or as a conseque	31100 017.					- 1	year	2	
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	ence of):									
	cate be executed physician and s the burial-transit		that initiated events resulting in death) Last	o (or as a conseque	sequence of):							_	
8760	ificate k ng physias the l	Medical	d										
Box 68	ss that the death certi igned by the attendin be detached for use	Completed by Physician/N	in the past 12 months?	outcome of pregnan we Birth 2 Fetal egnant at time of de nknown	death 3	Ectopic pregnand Other (specify)	су		230	d. Date of delive Month	rery Day Ye	ear	
s, P.O.	uires that the signed by Id be detac		Part II. Other significant conditions contributing to	death but not resu	Ilting in the u	nderlying cause gi	ven in Part I.				he cause of dea	/	
Record	The law requires cate has been sig page 2 should b							24a. Was auto perfo		24b. Were auto prior to co death? 1 \sum Yes	ppsy findings avompletion of car	vailable use of	
ita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital:			Oth	lace of Death (Chec	k only one)					
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	ding Phys h. After this funeral dir	ate: To	27. Manner of Death 1 Natural 5 Pending	☐ Inpatient 2 ☐ I te of injury onth, Day, Year)	ER/Outpatier 28b. Time of injury	at 3 □ DOA 28c. Injur worl	y at k?	ome 5 L Resi 28d. Describe I			y)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		, street, factory, office 28f. Location			(Street and Number or Rural Route Number, wn, State)					
Ω	To the Hospital within 24 hours To the Funeral I completed filled	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 3 Certifying Nurse Praction	pasis of examination	and/or invest	tigation, in my opini	ion, death occurred a	t the time, date :	and place, an	nd due to the ca	ause(s) and man	ner stated.	
_	To the within To the comple	Σ	only one) 3 L Certifying Nurse Practions 29b. Signature and title of certifier	. To the best of filly	ionioage, (29c. Licens	se number		29d. Date s	igned (Month,	Day, Year)		
			20 Name and address of person who completed c	ause of death (Item	23a) (Type. F		18136		4-5	-20	1 [_	
			Robert A. DUNCAN	MD 619	5 W.	McPha	n/Rd R	SeQ A	RMI	0 210	14		
	Sta Registr		310te filed 5/02/0 fax. Year)	. Registrar's Signati	ure	A							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7/2/2011 Physician/ Year Blanche M. Conaway 9:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months 1 M 2 XF Manth 2 1927 **Director** 83 MD 218-24-1753 Usual Residence of Deceden items 23a or 28a-f shov her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Hampshire Paw Paw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HC60 Box 20 25434 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iter Examiner 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3XXWidowed 4 ☐ Divorced White Year or Dates Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ည Norman Murray Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 HC60 Box 20, Paw Paw, WV 25434 Gail A. Slonaker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Pleasant Ridge Cem. 7/7/2011 Woodbine, MD 21. Signature of Funeral Service Licensee ²²Burrler-Queen Funeral Home & Crematory, CEMM 1212 W. Old Liberty Rd., Winfield, MD Part 1 nter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause in each line. shock or heart failu Imm. de Cause (Final disease or condition resulting in death) or heart failure. List only one cause Interval Between Onset and Death

2 Wells >eps (Physician/ Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the bunal-transit resulting in death) Last Due to (or as a consequence of): 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box (Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should let 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at e Hospital or Attending P 124 hours after death. e Funeral Director: After t 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Muse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 h To the Fur (Check the only one 29b. Signature and title of certi 29c, License number 29d. Date signed (Month. Day, Year) DO0 33280 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) 0

Registrar
DHMH 17 Rev 7/2009

State

GILIPTA

Date filed (Month, Day, Year)

JUL 0 6 2011

32. Registrar's Signat

SIE 101

CLIMBERLAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DUVal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltomore Medical Cente BU Anne (olen Washington 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-36-5919 1 X M 2 🗆 F Months (Month, Day, Year) 4 0 Country) Director Usual Residence of Decedent 28a-f show 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore XXYes 2 No 10f. Zip Code 21230 10g. Citizen of What Countr 10e. Street and Number 2110 Harmon Avenue Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 🕷 Specify: White ¥⊠ Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College_(1-4 or 5+) Mechanic Trucking Be 17. Father's Name (First, Middle, Last) Harry F. DuVall, Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Vivian Ellard and Mental ဂ 19a. Informant's Name/Relationship (Type, Print)
Gloria M. Wist / Daughter Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ginger Drive, Gambrills MD 21054 19b. Mailing . 2398 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Cedar Hill Cem. 6/28/11 Baltimore MD 4 Donation 5 Other (Specify) Doda 22 Name and Address of Facility tevens Funeral Home, Inc. 1501 E. Fort Ave Baltimore MD 21230 Senseture of Paneral Service Licensee Victor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Stage liver disease Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cardio myopatho 1 Yes 2 No 3 Probably 4 Lunkriown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? director, page certificate 2 🗌 No To the Hospital or Attending Physician: The Within 24 hours after death.

To the Funeral Director. After this certification of the Funeral Director. After this certification in by the funeral director; the Completed filled in by the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the function of the funeral director; the function of the funeral directors and the funeral directors are completed directors. 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D17692 who completed cause of death (Item 23a) (Type, Print) Baltmore Washington Medical Center. Dama Koldo 31. Date filed (Month, Day, Year, State 06

DHMH 17 Rev 7/2009

Registrar

11-04932 William Henry Da	aug	otate of that yard / Bopartmont of Floater and Montain		ible. 2011	2 26
Physicia Madical Evention			2. Date of Death	g. No. Day Year	3. Time of Death
Medical Exami	ner	WILLIAM HENRY DAUGHTRY, III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 2, 201		0007 hrs
		Johns Hopkins Hospital Baltimore			
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs 20 Yrs.		(MM/DD/YYYY) 9. Birt Foreign Cou	
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with the Maryland ns 23a or 28a-f sho be ootified at oocs.	al Director	1325 STONEWOOD ROAD 10f. Zip Code 21239		g. Citizen of What Coun	try?
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nore, MD 21215-0036 signs 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic evect, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT STUDENT	ired)	16b. Kind of Business/Ir	•
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, MD and 2 shou eath and N tem 27 is n traumatic	٦	GLORIA STEWART GRANDMOTHER 8516 LUZERNE RO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	AD. RAN		MO.21133
Baltimore, MC permit. Pages I and 2 st Department of Health an Important: If item 27 injury or other trauma		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: O7	11/80/	BALTIMOR	E, MD
Bal permi Impo injur		1905 YORK ROAD	· BARTII	MORE, MD	VERAL SCUS ·21212
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) to the Chin and the Back of Neck Due to (or as a consequence of):	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause			
	al Exar	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
60, ate be ex hysician	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	nncy	Month Da	ay Year
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F Vit	의			esidence 6 Other:	
Sion of Atteoding Ph death.	Certification:	1 Natural 5 Pending Jul (Month, Pay, Year) 2 Accident Investigation 2 Jul (1, 2011 2011 2011 2011 2011 2011 2011 20	28d. Describe ho Subject shot		
Division To the Hospital or Atteodit within 24 hours after death. To the Fuorral Director: A completely filled in by the til		20a Carlifor	or Town, Stat 1400 blk Stonev	vood and Kelway, Ba	Itimore, MD
To the Ho within 24 Fo the Fu	edica	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	due to the cause(s t the time, date an	s) and manner as stated d place, and due to the	l. cause(s)
	2	29b. Signature and title of certifier O.C.M.E.	- 1	29d. Date signed <i>(Monti</i> July 2, 2011	h, Day, Year)
4		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 212	223		
Sta Registr	te ar	31. Date filed (Manta Bar Year) 32. Registar's Signing I			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy B. Driver July 10:30^A M 20¹1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕮 F Days Hours 217-24-5106 oct. 26,1928 Country)
Baltimore, **Director** 82 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2603 Linwood Road 21234 United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. 以り句 みの((10 竺 Baltimore) Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 Divorced 4 Divorced White er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Doctor Office n and Mental Hygien

7 is marked other the
raumatic event, the 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marker r traumatic e Norman Bassford Grace Mansdorfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Driver/Husband 2603 Linwood Road, Parkville, MD 21234 item 2 Date 7 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State Moreland Memorial Park July Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nediate Cause (Final Onset and Death Ph_sician/ sease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Vear 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and litle of Jertifier 29c. License number who completed cause of death (Item 23a) (Type, Print) State th Day, Year)
6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1005 Hewilt Way Baltimore N/A5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF Days Hours Min March D3 Year 1930 207-22-7501 81 Director Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State 10b. Count with the Maryland 10c. City, Town or Location 10d. Inside City Limits s 23a or zou must be notified a' Director Baltimore Maryland N/A1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral must k 1005 Hewitt Way 21205 United States permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Specify. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Ellsworth F. Travis Kathyrn Deubler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bohrer / Daughter 1005 Hewitt Way, Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. 07/02/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Physician/Medical Examin Cause (Disease or linjury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 L own Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred atural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Print) 31. Date filed (Month, Day, Year)

JUL 0 6 2011 State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 5, 2011 MAUREEN MARGARET DIEMER 6:45A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2525 Pot Spring Road Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 091-22-0646 1 🗆 M 2 💢 F 06/19/1925 Par New York Director Vrs Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Timonium Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2525 Pot Spring Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Chemist Environmental Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant; If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Davoren Jeannette McClean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 109 Tynewood Drive Turtle Creek, Pennsylvania 15145 Dolores Yount 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place GreenMount Crematory 20c. Location - City or Town, State 07/08/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 95 Medical resulting in death) Due to (or as a consequence of) **Examiner** 4 earc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Ducito for as a consequence of, burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ 23d. Date of delivery Box in the past 12 months? Dav Year Pregnant at time of death signed by the a be detached for Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes 2 Your or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this uneral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗔 Certifying Nurse Practioner: To the pestof my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d, Date signed (Month, Dav. Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. \$300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DIEMER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 8:20P MARGARET KEENE EBY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** 01/2671925^{ear)} Days Months Hours Mary Tand 1 M 86 218-16-1440 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City. Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland at **Funeral Director** notified 1 Tes 2XX No Towson Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ms 23a or must be r USA 21204 615 Chestnut Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, i "natural", or item edical Examiner m 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?

1 Yes 2 XX Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes XX No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 3 ₩Widowed 4 □ Divorced and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Cahill Arthur Valentine Keene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6406 Pratt Avenue Baltimore, Maryland 21212 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Son Edward C Eby 20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State New Cathedral Cemetery 07/07/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral 6500 York Road baltimore, Maryland 21212 disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest allure. List only one cause on each line. 23a. Part 1. Enter the disease or compleshock, or heart failure. List only on Approximate Interval Between Onset and Death Immediate Cause (Final 0 Coweeks Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death Ectopic pregna Month Day Year Pregnant at time of death 5 Other (speci is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Mtery disease CONDIANY autopsy death? 26. Place of Death (Check only one) Be 25. Was case referred to medical examine?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other Specific 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 1 Natural
2 Accident 5 Pending found on Floor FALL 1 Yes 2 No UNKNOWN M MAY 18, 2011 Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living Facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 615 Chestnot Avenue Towson, md 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier and address of person who completed cause of beath (Item 23a) (Type, Print) N. Charles GBMC 6701

Registrar
DHMH 17 Rev 7/2009

State

2011 /

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ENNIS Physician/ ANNA IRENE JUME 30,2011 6:10P Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 773171935 Country) 1 M 2 X F MD Director 218-32-1582 75 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Frederick Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21771 USA 14405 Peddicord Rd. items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. þ 1 Yes 2 No 1 Never Married 2 Married o 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Her Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Ida Magers Howard E. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cornelius E. Ennis/Husband 14405 Peddicord Rd., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Resthaven Mem. Gardens 7/6/2011 Frederick, MD 4 Donation 5 Other (Specify) Signature of Funeral Se vice License ²²Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PROBABLE ENCEPHALOPATHY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPSIS PRUBABLE Sequentially list conditions Examine Durit for as a consequence of cause. Enter Underlying attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 X No မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: At Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number within 24 hours after de

To the Funeral Directo

completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifie 29c. License number

State Registrar

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ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Ju^N199th 2, 201√1 Eleanor Margarette FINVER 9:45 P Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Kensington Examiner County of Death Montgomery Kensington Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 27 **Funeral** Birthplace (State or Foreign Country) 1 M 2 XF 85 Months Days Hours 083-20-2999 **Director** 1926 Germany Usual Residence of Decedent or 28a-f shov 10a. State 10b. County be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 🛚 No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 3618 Littledale Road 20895 United States traumatic event, the Medical Examiner must 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation National Institutes of (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Health/U.S. Government Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Hortense Lauer 2 Hans Wormann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Finver, Son 2 Clemson Court, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 07/07/11 Olney, MD . Signature Funeral S 122. Name and Address of Facility
Torchinsky Hebrew Funeral Home 64 Carroll St., NW, Washington, DC the mode of dying, such as cardiac or respiratory arrest, Part T. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Congestive Heart Failure Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic Renal Failure Sequentially list conditions, Examine Due to (o. as a consequence or). il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hypertension sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Dementia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Hospital or Attending Physician; The law requires that the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 X No 1 ☐ Yes 2 ☐ No Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: မြ 1 🗌 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📉 Other (Specify) Assisted 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D 53691 July 5, 2011 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D., 3200 Tower Oaks Blvd., #110, Rockville, MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6/30/2011 Dorothy Evelyn Farver 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Carrol1 Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Months Davs 3/24/1925 Director 419-22-8330 86 AL Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Carrol1 Mt. Airy 10e, Street and Number 0f. Zip Code 10g. Citizen of What Country? Funeral 4400 Roop Rd. 21771 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XXWidowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If item 27 is marked any injury or other transpores ဂ Levy Tyson Fuller Arthur Ruth Coker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Farver/Nephew 4400 Roop Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 Doylation 5 Other (Specify) 7/7/2011 Taylorsville UMC Cem. Taylorsville, MD uneral Service Licens 21. Signat ²²Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. P rt 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Immeriate Cruse (Final disease or condition resulting in eath) Onset and Death Physician schemic Medical Examiner anlox destease Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined filled i Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D64408 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEHARI, MD 200 MEMORIAL AVE WESTMINSTER MD

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Registrar

31. Date filed (Month, Day, Year)

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32 Tegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ reev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University Ot and Move 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days 579.70,9691 Hours 60 Alabama Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** andover MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Brightseat Rol 20785 SA permit, Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) ATEVING Professional ATEVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IZOIA JACKSON 19a. Informant's Name/Relationship (Type, Print) days her 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 13 Alencia Conninguam Greenbelt MD 20770 Parkway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State FORT Brentwood, MD INCOIN 4 ☐ Donation 5 ☐ Other (Specify) 420 H St. NE, Signature of Funeral Service Licensee Home wasH. DC, 20002 23a. Part 1. Exter the disease, or complications that sed the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Fequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? stem organtaillie 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? renal tailwe 24a. Was an autopsy perforn 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural work? 5 Pending nours after death. neral Director: Aft I filled in by the fur 2 🗌 No Accident

3 Suicide

4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

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completed file 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 11015382 upiversity of Mary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (M State 6

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:434 2011 7177 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Hospice 10WSON If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 Months Hours Month, Day Director Usual Residence of Decedent 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director MD Baltimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give BIACK 3 ₩idowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12th arade Cosmetobal eautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elliah Williams, Sr. Wilar Dora 19a. I mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gliria A. Ginffin Daughter item 27 Hawksbury Koad Alkeguille) 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 07/09/2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Licensee Valling C. Greene Fundal Services 22. Name and Addres of Facility Ruad Faridalistown MD 21133 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, swell as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause Final Onset and Death endocarditis Physician/ erin disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** + Sequentially list conditions, If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year ate has been signed by the a page 2 should be detached to 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Moci 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2' No Hospital Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 205

State Registrar

31. Dyna illed Machth Day Year)

32. Regisfar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death edent's Name (First, Middle, Last) 3. Time of Death 2-2011 Physician/ 6:00A M Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 9. Birthplace (State or Foreign Country) 8. Date of Birth Age (In yrs. last birthday) **Funeral** (Month, Day Year) 1 🗆 M 2 🖪 Yrs. Director or 28a-f show 10d. Inside City Limits Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No 10g. Citizen of What Country? Funeral [21163 venue 0041 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 2 1 No Specify Yes. Give 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, er's Name (First, Middle, Maiden Surname, မ osser Informant's Name/Relationship (Type, Print) City or Town State Zin Code Place of Disposition (Name of Method of Disposition emetery, crematory ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ballimore, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Day Month Pregnant at time of death To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 I No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 1 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and 31. Date filed (Month, Day, Year) State 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deat Baltimore Center N If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Hours Country) MD **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director MD Baltimore 1 Yes 2 No 23a or 10e. Street and Number 10g. Citizen of What Country Funeral heservior items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or i injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College,(1-4 or 5+) Elementary/Seconday (0-12) 12th grade Master Welder Eastern Sainless Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Harver Kuth Httman 19a. Informant's Name/Relationship (Type, Print) (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Johnson Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 a 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Crownsville, MD 07/08/2011 CransvilleVAC 4 ☐ Donation 5 ☐ Other (Specify) permit.
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Importe
any inju Vaughor C. Greene Pulleral Services 21. Signature of Funeral Service Licensee Road Randallstown MD 21132 23a. Part 1. Ent x the disease, or complications that caused the death. Do not enter the mode of dyin so ch as cardiac or respiratory arrest shock, or near it ilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final disease or condition Physician/
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 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural Division 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Nancy Carol Hannah 2:29 P. M July Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford 3835 Memory Lane, Unit C Abinadon If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1951 1 □ M 2XXF Months Days Hours June 15 New Jersey 217-58-8020 60 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 28a-f 1 Yes 2 XNo Harford Maryland Abingdon 10 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? United States Funeral items 23a 21009 3835 Memory Lane, Unit C America Οf 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Widowed 4XXDivorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanora Clavell Samuel Gore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 232 Timber Grove Road, Reisterstown, MD 21136 Jenny E. Meyers (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State July 6, Ali Faiths Crematory or other place)
& Chape I 1 Burial 2 XX remation 3 Removal from State injury or 4 Donation 5 Other (Specify) Manchester, Maryland 2011 Signature of Funer Eckhardt Funeral Chapel, P.A. 22. Name and Address of Facility any in once, XMau 11605 Reisterstown Road, Owings Mills, MD 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dise me or condition resulting in death) Medical within 24 hr Due to (or as a consequence of) Examiner ea ronav Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ears Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (ou a va consequence of): resulting in death) Last ears Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Unknown cate has been signed by the page 2 should be detached 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 1 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 24 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: Af
empleted filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State
Registrar

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32. Registrar Signa

of person who

31. Date filed (Month, Day,

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Julv2011 Physician/ 8:20 P. M Yvonne R. Haynes Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Crownsville 919 Buttonwood Trail 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days 1 🗆 M 2 🕱 F 0870971932 New Hampshire 78 007 30 1444 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 X No New Freedom York PA. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. Funeral 3 Heritage Farm Road 17349 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married Yes 2 X No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) C & P Telephone Co. Billing Adjuster Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lydia Richard Antonio Richard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Crownsville, Maryland 21032 Donna Rober / Daughter 919 Buttonwood Trail 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗌 Burial 2 🕱 Cremation 3 🗍 Removal from State Baltimore, Maryland 07/08/2011 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Puneral Service 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 iens 4001 Ritchie Highway Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ns t and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year for Pregnant at time of death 1 ☐ Yes 2 ☒ No 9 ☐ Unknown ned by the a e detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signe 1 be d 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s 1 Yes 2 No this certificate **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Daughter's Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\frac{1}{2} \) Other (Specify) 2 No 1 🗌 Yes 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ဂ္ 28a. Date of injury (Month, Day, Year) within 24 hours after used...

To the Funeral Director: After the committee filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? 1 Yes 2 No Investigation ☐ Accident ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Graphing Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on onth. Day. Year) 29d. Date signed (/ 29b. Signatu

25 State

JUL 0 6 2011

Peter Graze

30. Name and ad

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Registrar

2003 Medical Parkway Wayson Bldg. Suite 210 Annapolis, MD.

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Dhysisia	Registrar	OI Dealli	Reg. No.	3. Time of Death
Physician Medical Examin			Month Day Year July 1, 2011	
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		f Death
	5113 Bonnie Acres Drive	Ellicott City	Howard	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir		Birthplace (State or Foreign
Director	214.23.9122 11XM 20F 27	Yrs. Month's Days Hours Will	July 8 1983	Country)
áu a	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ncation		10d. Inside City Limits
*	NA INA CILIA			1 Yes 2 No
Maryland 28a-f show d at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
ith the Ma 23a or 23 notified	5113 Bonnie Acres Dr.	DIRIZ	lisa	
death with the Maryland or items 22a or 28a-f sho must be notified at once.		Was Decedent of Hispanic Origin? (S		- American Indian, Black,
r death wi	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White,	etc.
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215-0036 be filed within 7 mtal Hygiene. riced other than ent, the Medica	Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surname)	
4D 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 23a-f she mattic event, the Medical Examiner must be notified at one	torrest Garner Hall	Cynu	hia day li	FFT
D 21 Should I and Mer	Tiggle 1	iling Address (Street and Number or	Rural Route Number, City or Town	, State, Zip Code)
MD and 2 sho eaith and 27 is	20a. Method of Disposition 20b. Place of Dis	S SONNU HCYA	Date 20c, Location - 0	City or Town, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygene. Tant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner.	1 Burial 2 Cremation 3 Removal from State crematory o	r other place)	1=1. A. R.	n=: N10
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other trannantic event, the Medical Hygin or other trannantic event, the Medical Medic	4 Donation 5 Other Specify: A+Quin 2 Signature of Funeral service Licensee	2. Name and Address of Facility	3711 IGUNU	whie hub
Balti Permit. Departi Import	WIND IN Chartan + MAY 35	lackfinger Bom	38.71 0 1 0010	IMPISARY
Physician	23a. Pirt I. Enter the drawe, or complications that cause the death. Do not ent	er the mode of dying, such as cardiac	or respiratory errest, shock, or hear	rt Approximate Interval Between Onset and
/Medical	Immediate Cause (Final disease a. Methadone Toxicity	and cocaine use		Death
Zammer	or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			_
ted nsit	cause. Enter Underlying Cause (Disease or injury that initiated			
cuted and transit	events resulting in death) Last Due to (or as a consequence of):			
a a ex	■ MENDED 23a,27,28a-f,	per me,g917 7-25-	11 sm	
68760, ertificate be eding physicia	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of c	delivery
Box 68760, e death certificate be the attending physic ed for use as the burner	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn	ancy Month	Day Year
Sox leath of eath of for us	4 Pregnant at time of death 5 1 Yes 2 No 9 Unknown	Other (Specify)		
O. Boy hat the death by the att		ne underlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
res tha			1 Yes 2 No 3	Probably 4 Unknown
tal Records, P.O.				ere autopsy findings available for to completion of cause of
eco he lav ate has			performed? de	eath? ✔ Yes 2 No
Entification, p	25. Was case referred to medical	26.Place of Death (Check		
Vita	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other Nursi	ng Home 5 Residence 6	Other: Scene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buint completely filled in by the funeral director, page 2 should be detached for use as the buint completely filled in by the funeral director, page 2 should be detached for use as the buint completely filled in by the funeral director.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	المالية المالية	28d. Describe how injury occurre Unknown	ed
IVISION Or Attend after death. Director: d in by the f	Accident Investigation fd 7-1-11 fd 9	28 pm 1 Yes 2 X No		and Double Number City
Divi	3 Suicide 6 X Could not be determined (Specific found at res	-	28f. Location (Street and Number or Town, State) 5113 E Ellicott City, M	
Tospit Topit Tuner				
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner:On the basis of examination and/or invest			
F. 2 5 0	and manner stated. 29b Signature and title of certifier	29c. License number	29d. Date signe	d (Month, Day, Year)
	(with feet)	O.C.M.E.	July 2, 2011	I
	30. Name and address of person who completed cause of death (Item 23a)			
Ø V	Victor Weedn MD JD Assistant Medical Examiner 900	vv. Baltimore Street, Baltímo	ore, MD 21223	
Sta	a 31. Date filed (Month, Day, Year) 32. Replicar's Signature			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}2<u>011</u> July Isabelle S. Jorio 2 Medical 5:40 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Westminster Carroll Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD 1 □ M 2 🔀 F Months Hours 217-18-3279 89 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 🗆 Yes 2 🗷 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 St. Mark Way, Apt. 305 21158 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 ial Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beauty 12 Hairdresser Be 17. Father's Name (First, Middle, Last) Should be file and Mental F is marked of 18. Mother's Name (First, Middle, Maiden Surname) John W. Bennett permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e Lillian S. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Jorio-son 349 Narnia Dr. S, Grasonville, MD 21638 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moreland Mem Park 7-7-11 Parkville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home homa 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the in de of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a co sequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) burialresulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 5 Other (specify) Pregnant at time of death Month Day Year detached 9 Unknown 9 Unkn Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 1 Tyes Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy this certificate perform death? Yes director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 🗀 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . Signature and title of certifie 29c, License number 29d. Date signed (Month,

DHMH 17 Rev 7/2009

State Registrar of death (Item 23a) (Type, Print)

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:28 **JAMES** KNOX JR. JUNE 2011 Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death APITAL HEIGHT'S Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Hours Min 579-62-2137 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral SA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

Xyes 2 NoVIETNAM Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. Specify: Black "natural" Completed 3 Widowed 4 Divorced -ERA Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working HECHT'S than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the it. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other th njury or other traumatic event, the man tmen Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ AMES anie liam Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Urtis/daughter **Grason** Department of Health Important: If item 2: any injury or other tonce. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1

■ Burial 2

□ Cremation 3

□ Removal from State condover, MI 4 ☐ Donation 5 ☐ Other (Specify) armony Signature of Funeral Service Licenses Name and Address of Facility 120 H St-NE 20002 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Immediate Cause (Final Onset and Death METASTATIC CARCINOMA OF UNKNOWN PRIMARY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions ner Due to for en e nonnecuenne off If any leading to immedicause, Enter Underlying Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 VN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other 2 🗆 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗖 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending ☐ Accident completed filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD# 036896 JUNE 28, 2011

Registrar
DHMH 17 Rev 7/2009

State

DAVID M.

31. Date filed (Month, Day, Year)

LUSE,

VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

PO Box 195 Sykesville, MD 21784

HAIGHT FUNERAL HOME & CHAPEL, PA To the Fuo (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 30, 2011 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner 32. Registrar' Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 2:00 P M KIEHLE JUNE NNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore City BALTIMORE HARBOR HUSPITAL CENTER 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Feb. 16, Year) 192<u>8</u> Months Days Hours 1 🗆 M 2 😾 F New York 83 122-20-4731 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State filed within 72 hours after death with the Maryland Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö ral", or items 23a or Examiner must be r Funeral 234 Glen Rd. 21060 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha the V.A. Medical System Medical Clinic Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Faladay Richard Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Chalmers Ave., Glen Burnie, Maryland 21061 Claire F. Kiehle / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Catonsville, Maryland Metro Crematory, Inc. injury (Conation 5 Other (Specify 21. Signa aral Ser Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. shock, or heart failure. List only one cause on each line, Onset and Death Immediate Cause (Final Physician SEVERE SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and trar Due to (or as a consequence of): attending physician a for use as the burlal-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 menths? 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate 1 Yes 2 No 21 No the Hospital or Attending Physician: 25. Was case referred to hedical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 잍 1 Inpatient 2 🗆 ER/Outpatient 3 DOA after death. Director: After this 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Sulcide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) bern Res - 00 June 25 2011 Resident 3001 South Hanover 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

ENBE

32. Registrar's Signature

WOLDE

JUL 0 6 2011

Baltimore

2122

MD

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

and manner stated

32. Registra Signat

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ana Rubio MD.

29d. Date signed (Month, Day, Year)

July 4, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Charles 30^{Day} 2011 Francis Klug 4:55 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Baltimore Parkville 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Month, Day Months Hours Director 220-01-6678 90 Usual Residence of Decedent oriant: it item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at e. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Tes 2 No Maryland Baltimore Parkville 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 2313 Park Terrace 21234 U.S.A. 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify. If Yes, Give 1942-46 Specify: White 3 - Widowed 4 - Divorced Year or Dates. 1050 5/. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)

1 year Elementary/Seconday (0-12) Office Manager Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clement Louis Catherine Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 Joan Duffy Klug (wife) 2313 Park Terrace Parkville. 8800 Walther Blvd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7-6-11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 23a. Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCVD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Dire to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death Month Dav Year s been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Par Kinson's Disease 1 Yes 2 No 3 Probably 4 Unknown retention 24b. Were autopsy findings available prior to completion of cause of urinary 24a, Was an performed 1 Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: ,
completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier amon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wa Ither Moniac 8800 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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A. KARPOOK

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			Registrar 1. Decedent's Name	e (First, Middl	e, Last)					37 11110		<u> </u>		2. Date of D			\\frac{1}{2} = 11	3. Time of Death
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	Examin		4a. Facility Name (if	AM AR	ITA		105			E	City, Town, o	Mox	RE			c. County o	ne	
	Funeral Director		5. Social Security N 214–20–2285		6. Sex	1 2 XX F	7. Age 85		ast birthday Yrs.	Moni	hs Days	If Unde Hours	Min.	8. Date of B 02/17/1				nplace (State or Foreign aryland
	nd thow at	2	Usual Residence of 10a. State	Decedent 10b. County	,			10c. Cit	y, Town or l	ocation							Т	10d. Inside City Limits
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	with the 23a or 2	Funeral Director	10e. Street and Nun 6219 Northw		ve		-			10f	Zip Code	212			10g. C	Citizen of Wh USA		intry?
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Marr		rried	Was Dece Armed Fo 1 Yes If Yes, Gir Year or D	orces?XX 2 XXX ve	ver in U.S No	S. 13		ecedent of I specify Cub es 2			ecify Yes or No Rican, etc.))-		, White,	ican Indian, , etc. White
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21215-0036	within 72 giene. er than '	Completed	Elementary/Sec		grade ·	College (*		+)	life.	etary	use retired)	or worr			Baltim	ore (County
Maryland	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (Last)									ne (First, Middle Poisal	e, Maidei	n Surname)		
Mary	12 should lith and M 27 is ma r trauma		19a. Informant's Na John D Karp		ship (Type,	Print)	Sc	n	1	-				al Route Numb			ate, Zip	Code)
ore,	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disp	osition	2 □ Po	moual from		20b. F	Place of Dis	position (Date		Location - C	City or 1	Town, State
Baltimore,	t. Page tment rtant: I	4	☐ Donation	5 Other (Specify)	A.	i State		eland	Memor	ial Pa	rk		1/2011		ltimore	_	
Bal	permi Depai Impo any ir once.		21 lignature of Fu	Mu	Lice ee	/XP	II A	Di	15	22. N am				chell-Wie altimore,				Hame Inc
			23a. Part 1. Enter t shock, or hea	rt failure. List	r complice only one o	tions that ause on e	caused ach line	the deat			node of dyi	ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
Ü	Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a .	Due to			lence of):	cree	rova	coule	ar a	cci den	t (CVA)		Olisot and Doam
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90	te be exe hysician he burial	l= 1	resulting in death)	Lasi	d.		(0) 83 8				_							
. Box 68760	Attending Physician; The law requires that the death certificate be or death. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 5	months?	230	. If yes, ou 1 Live 4 Preg 9 Unk	Birth gnant a	2 🗌 Feta	al death 3		pic pregnar r <i>(specify)</i> _	псу			-	23d. Date Mont		very Day Year
P.O.	that the	by Pł	Part II. Other signif	ficant condit	,		,			e underly	ing cause g	iven in Pa	rt I.					the cause of death?
rds,	equires en sig ould b	ted	1. Coro	nary	art	ery,	d)	SRES	e					1 [Yes :			obably 4 M Unknown
3eco	he law rette has be	omple	2. (on	gertive	e h	eart	f	ai/ur	e					pei	as an topsy rformed? s 2 12/1	pr de	ior to c eath?	opsy findings available ompletion of cause of
tal	cian; T ertifica ector, p	To Be C	25. Was case referrexaminer?			pital:							eath (Ched	k only one)				
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Division of Vital Records,	al or Atte s after de l Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ				iry - At ho c. (Specif)		street, fac	ctory, office				(Street a		or Run	al Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2	Medical	Examiner	On the ba	asis of e	xaminatio	n and/or inv	estigation	n, in my opin	ion, death	occurred a	nd due to the out the time, date on the time, date on the time, date to	e and place	ce, and due	to the c	ause(s) and manner stated.
	To the To the Comp	2	29b. Signature and	title of certifie	er				,		29c. Licens					Date signed		
			Anon								_	000				1021		
les	/		30. Name and addr	ess of person	who com	Goo.	ise of d	eath (Iten	1 23a) (Type	e, Print)	acera	01 4	601	I ACH R	AVE	N RE	VD.	BALTIMORE nD, 21239.
г	Sta Registr		JUL 0 5 20	h Day, Year	nous	32	Registra	s Signa	ture			ر د د .	UUL	JU - 1/ /	- L-1	V 126	n	np, 21239.

1-04782 errence Kenny,	Jr.	Please Type State	or Print in I								ible	201	2129
		l- For State Registrar			ificate						g. No.		
Physicia Medical Examin	ш.	Decedent's Name (First, Middle, Language Terrence Kenny								Date of Death Month June 27, 2	Day	Year	3. Time of Death 0643 hrs
		4a. Facility Name (if not institution, g 200 feet E of Red #4 in t		er)			r, Town, or erdeen P					County of Death a rfor d	1
Funeral Director		212 66 5046	Sex 7.	Age (In yrs. las 55			nder 1 Year nths Days		_	8. Date of Birtl 03/27/	,	1	thplace (State or gn untry) NY
laryland 28a-f show any at once.	ē	Usual Residence of Decedent 10a. State 10b. County MD Harfor	·d	10c. City, T	own or Loc	ation							10d, Inside City Limits 1 Yes 2 No
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£ 1 5	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Deceded Armed Force 1 Yes If Yes, Give Year or Dates:			Yes, spe		, Mexican	, Puerto Ri	ify Yes or No- can, etc.)		4. Race - Ameri White, etc. Specify: Whi	cen Indian, Black, te
036 ithin 72 hours a ane. r than "natura Aedical Examir	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade o		during	most of w	vorking life.		kind of wor use retired			nd of Business/I $1f$ – ${ m Emple}$	•
filed within Hygiene.	_	17. Father's Name (First, Middle, Las	·							irst, Middle, M	aiden S	Surname)	•
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. a 27 is marked other than numaric event, the Medica	일	Terrence Kenny, 19a. Informant's Name/Relationship Patricia Kenny/S						t and Nun				or Town, State	, Zip Code)
ages i and 2 shou nt of Health and Nt. If item 27 is n other traumatic	ł	20a. Method of Disposition 1 Burial 2 Cremation 3			ace of Disp ematory or	osition (N	lame of cen	netery,		Date		ocation - City or	Town, State
	L	4 Donation 5 Other Specia	fy:	Che	sapea	ke Cr	cem.		201	11		ltsville	
Balti permit. Departur Importa		21. Signature of Funeral Service Lice	Remo	NUO								.Lohrman , MD 21:	
Physician /Medical		23a. Part I. Enter the disease, or con failure. List only one cause on Immediate Cause (Final disease					e of dying,	such as c	ardiac or re	espiratory arres	st, shoc	k, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co										
=		events resulting in death) Last	Due to (or as a co	nsequence of):									
	Jedic	UNPENDED [AMENDED 23c. If yes, outc	come of preons	incv						23d	Date of delivery	
lox 68°		3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant	at time of deat	2 🔲 1	Fetal deat		Ectopic	pregnanc	y 		•	Year Year
P.O. E es that the d igned by the detached	<u>a</u>	Part II. Other significant conditions		ath but not res	ulting in the	underlyi	ng cause g	iven in Pa	ırt I.				the cause of death?
cords, P.C. aw requires that nas been signed I 2 should be deta	Completed	Atherosclerotic cardiova	scular disease							24a. Was ar	1	24b. Were au	ably 4 Unknown topsy findings available ompletion of cause of
tal Reco										perform 1 Yes 2	ned?	death? 1 ✓ Ye	s 2 No
Vital Rec bysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2 E	R/Outpatie	nt 3		Othor	(Check only Nursing H		esiden	ce 6 🗸 Other	; Scene
ling Ph	- -	27. Manner of Death 1 Natural 5 Pending	28a. Date of li	njury 2 y,Year) I	8b. Time o FOUND: 0643 hrs		28c. Injur	y at Work	? 28	d. Describe ho	w injur		
Divisi	Certification:	2 Accident Investiga 3 Suicide 6 Could no determin	t be 28e. Place of	Injury - At hom		eet, facto	ry, office bu	uilding, et	c. 28				ral Route Number, City Aberdeen Proving Gr
8 - 3 > 1	Medical C	29a Certifier	clan: To the best of er:On the basis of eand manner state	xamination and					ice, and du	e to the cause	(s) and	manner as state	ed.
F.3 E.8	Me	29b. Signature and title of certifier	200ai	~		2	9c. License					ate signed (Mor	oth, Day, Year)
უ ∨	İ	30. Name and address of person who	completed cause of		,	altimore	Street,	Baltimo	ore, MD 2	 21223			
Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature									

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ An M Le Medical 4c. County of Beath timore 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Randallstown **Examiner** Seasons Hospice at Northwest Hospit If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month/Day/Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-30-7241 1 M XX F Days Hours Months MD Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location Catonsville 10d. Inside City Limits notified at Director MD Baltimore 1 🗆 Yes 2 🗒 No 28a-f 10f. Zip Code 21228 ö 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 16 Fusting Rd be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates White Specify. Completed Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
BOOKKEEPET 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Beswick Margaret Ellenberger traumatic 19a. Informant's Name/Relationship (Type, Print)

Donald Stoval / Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1340 Andre Street, Baltimore MD 21230 Department of Health ar Important: If item 27 is any injury or other traconce. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 7/6/2011 Baltimore MD 4 Donation 5 Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 e of Euneral Service Licensee 1C or P. Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ REBRA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year g Unknown Division of Vital Records, P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of the Funeral Director: After Inpleted filled in by the funeral Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** evasseur JULY 2011 Illiam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Hours **Funeral** 1 🖁 M 2 🗆 F 15 Baltimore, Maryland February 14,1996 182-76-3459 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Freeland Maryland Baltimore Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21053 United States 20100 Gore Mill Road Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces
1 Yes 2 If Yes, Give 2 No 1 XNever Married 2 Married or, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Never Worked Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susan Otto William R. Levasseur, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20100 Gore Mill Road Freeland, Maryland 21053 Susan Gilbert (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel—Bel
Air : If item 2 Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition July 05, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Monkton 23a. Part 1. Enterptine disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 16924 York Road Monkton, Maryland 21111 Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASTROCYTOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the as nding p use a 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 - Fetal death 1 Live birth Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No detached i PO. 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? page 2 2 No 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be examiner? Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 1 X Inpatient ပ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: al or Attending F s after death. I Director: After t Injury 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) the Hospital 24 hours 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hounded to the total to the funer completely file Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number Moand Mes 2ES -000 July 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 600 North Wolfe St, Baltimore, MD, 21287 MONICA 31. Date filed (Month, Day, Yea JUL 0 6 2011 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc g917 7-6-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 / Physician/ Leuschner Sk. 149 PM MAR Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0+ Baltmore If Under 1 Year If Under 7. Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F June 23, 219-18-8499 Maryland 85 Director Jsual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Anne Arundel Linthicum Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 USA 404 LaClair Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education School Principal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LeElla Mae Tapman Charles Richard Leuschner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 257 Hemingway Lane, Severna Park, MD 21146 Glenn Leuschner - SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06-15-2011 Baltimore, Maryland Metro Crematory INC 21. S. nature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland INC Patrik Fleming 299 Frederick Road, Balto, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Severe Aortic Stenosis Immediate Cause (Final Onset and Death hysician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No n signed by the a Id be detached f 1 ∐ Yes ∠∟ 9 ☐ Unknown Part II. Other significant conditions contributine to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown completed filled in by the funeral director, page 2 should 24b, Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Hospital or Attending 5 Pending injury work? 1 🗌 Yes Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year) P25662 cause of death (Item 23a) (Type, Print) 22 State 6 Registrar

Ratimore Manyland 21215-0036

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear 6:15A ARNOLD LTPMAN 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore N/A Baltimore 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Min Month Pay Year) 30 Director 217-24-4348 81 MD Usual Residence of Decedent show 10a. State 10b. County with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3503 OLD COURT ROAD 21208 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESMAN HOME IMPROVEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ injury or other traumatic HARRY LIPMAN TILLIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau REGINA LIPMAN/WIFE 3503 OLD COURT ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/2011 TIFERETH ISRAEL CEM BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ End Store 2 Due to (or as a con Juence of) End disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician all for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day ☐ Pregnant at time of death☐ Unknown the ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Alzheimer disease Completed 1 Yes 2. No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsv death? certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗹 No ဂ္ 1- Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1-Natural work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death.

e Funeral Director: A sleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted 2 L 3 L within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cecilia 4shii - Tamashiro RES-30 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W Belvedere Are, Rathure MD 21215 Yshii-Tamashiro Ceulia Sinai Mospital of Buttmore 31. Date filed (Month, Day, Year) State 0 6 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 030 AM **Physician** 201 ivian Maddox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Western Maryland Hospital Center Hagerstown If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 84 GA Director 255-30-3856 Aug 8 1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Berkeley Springs 1 ☐ Yes 2 📉 No WV Morgan Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with ealth and Mental Hygiene. USA 25411 29 MDG Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XNo Baltimore, Maryland 21215-0036 1 □ Yes 2 1 No Specify Specify: white 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) cashier traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked c Anniemae Jackson James Franklin Kilpatrick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29 MDG Way, Berkeley Springs, WV 25411 Department of Health a Important: If Item 27 Is any injury or other trainonce. Anne Maddox (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, MD 7-6-11 Crest Lawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Aprolonding of P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each chiline. Immediate Cause (Final disease or condition resulting in death) Physician /Medical 2 mestes Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Distriction 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ Ne 24a. Was an 9 page 3 1□ Yes 2/ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 🔀 Inpatient Other: 1 Tes 2 1 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 2 🗌 No after death.

i Director: A
d in by the fu 1 Yes 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar

-RADCISC DOKADE 31. Pate filed (Month, Day, Year) JUL 0 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

Hagerstown, MD 21742

29c, License number

1500 Pennsylvania Averue

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 3^{Day} 2011^{Year} 10:30am Ruth Elizabeth Mills Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Winfield Senior Constant Care Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. OCt. 24. **Director** 220-36-9673 88 1922 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 280 E. Watersville Road 21771 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: marked other than "natural", 3 Widowed 4 Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Susie Florida Sullivan William Arthur Sellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marsha Zimerman (Pers. Rep.) 6502B New London Road, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
All County Cremation 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/6/2011 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in nterval B tweer Immediate Cause (Final Death Ph_sician/ disease or condition resulting in death)). Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unkno Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Funeral Director, After this certificate has le Funeral Director, After this certificate has le Funeral director, page 2: autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated прleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D33681

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year

s. gares

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Way

1380 Progress Way

32. Registrar's

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 30 per dvr g917 7-6-11 vt

For amend item 19a State of Magyland / Pepartment of Health and Mental Hygiene
State
Registrar

Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** a OUI 0 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 0 last birthday) 7. Age (In yrs. 8. Date of Birth (Mgnth, Day, 9. Birthplace (State or Foreign Country) **Funeral** Months Days 1**X**M 2□ F 8 140-20-5798 Yrs. Director amaen Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director estminster 1 Yes 2 No MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any Injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 NYes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Air Force Technical Writer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John McKelvey Rita Mae Foley ျှ 19 Informant's Name/Relationship (Type Print) Catherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McKelvey/wife 3832 A Baker Road, Westminster MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cem 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/24/2011 4 □ Donation 5 □ Other (Specify) Berlin 21. Specture of Uneral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Live /Medical Examiner 41 415. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed illar months Gustric and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) ed by the a detached f 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 autopsy certificate 25. Was case referred to medical examiner? 1□ Yes al No Hospital or Attending Physician: funeral director Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 \(\sum \) Nursing Home Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) Assisted Living 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natura! n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Fune To th.
Avithin 2.
To the Fu 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) Physician tanily 20/11 6 HOO7 0147 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Thaker 1564 Opossumtown Pike Frederick, Md. 21702 32. Registra s Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 03-2011 Physician/ MADDOX 10:10PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death GILCHRIST HOSPICE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F 54 **Director** 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** ems 23a or 28a-f sh r must be notified a MD BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 336 E. BELVEDERE USA 21212 "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Specify: BLACK Year or Dates 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) BOYS' LATIN SCHOOL Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene HOUSEKEEPER OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ CLIFTON LEROY GEATHERS WILHELMINA COOPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FATERIA MADOOX DAUGHTER of Health AVE. BALTO, MO. 21239 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/11/11 BAUTIMORE, MD MT. ZIUN CEMETERY 22. Name and Address of Facility VAUGHN GREENE FUNDEAL SCVS, PA 21. Signature of Fune al Service Licensee mo1553 YORK ROAD. BATTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Seventiated carcinoma Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month sate has been signed by the page 2 should be detached 1 ☐ Yes ∠ uz 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify oice within 24 hours after death.

To the Funeral Director: After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 3 eted cause of death (Item 23a) (Type, Print) on who com

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State

Registrar

Date filed (Month, Day, Year)

JUL 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 24, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F 219-12-5464 86 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ** any injury or other traumatic event ** 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes Ž No Baltimore MD Essex Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21221 8620 Kelso Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen M. Nash William M. Roeth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3331 Charles Street Fallston MD 21047 Rita Maszczynski /daughter 20b. Place of Disposition (Name of Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/6/11 Baltimore MD 4 Donation 5 Other (Specify)

21. Signature of Fureral Service License 22. Name and Address of Facility 300 Mace Ave, Balto. MD en Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complication shock, or heart failure. List only odd Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the L IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nas 1 ☐ Yes 2 1 No Yes certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 Cher (Specify) 1 Tes 2 ER/Outpatient 3 DOA Inpatient 2 completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) Pending investigation 1 Yes 2 No M 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and itle of certifier 29d Date signed (Month, Day, Year) 29c. License number 30. Name and address of completed cause of death (item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ : 28 PM arion 2011 a Medical or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town Examiner Maryland Hospita intor orges If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** ial Security Number 1 M 2 □ F Months Days Hours Min (Month, Day, -02-88 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location death with the Maryland Funeral Director ral", or items 23a or 28a-f s Examiner must be notified Marvland zui +lano 1 Yes 2 No Georges 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 3607 20746 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Ves 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. , 01 1 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than raumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion P am 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrace #8 Par Suitland Maryland 20746 Marion-Wif Kwav 27 Marion Important: If item 2 any injury or other once, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Pleasant Valley Memorial Park Annandale, Virginia Funeral Service 21. Signature of Funeral Service Licensee Robert B 2605 Shirlington Load 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 001-01 Physician/ MICCE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Live Birth 2 ☐ Fetal dea
☐ Pregnant at time of death in the past 12 months? Day for 5 Other (specify) Yes 2 No Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pe 1 🔲 Yes 2 🔲 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be filled in by the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide within 24 hours To the Funeral Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 710411

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

0 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea

JUL 0 6 2011

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Evelyn Lydia Murphy Ju1v 2011 7:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4908 Brookwood Road Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🛣 F Hours Min Director 212 12 1574 90 01/12/1921 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Maryland Director Anne Arundel Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4908 Brookwood Road 21225 by Funeral U.S. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 Divorced White er than "natura Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesclerk in Garden Dept. Montgomery Wards 7 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfred Cdin Jordan Ida Lucinda Grahe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4901 Brookwood Road Linda Galford / Daughter Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/07/2011 4 Donation 5 Dother (Specify) Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THORACIC AURTIC **Physician** ANEURYSM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROSIS Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPERTENSION
Due to (dr as a consequence of): and burial-t attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION PULMONARY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen OBSTRUCTIVE DULMONAR DIVENSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 ☑No 1 ☐ Yes 1 ☐Yes 2 ☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1∏Yes 2∏No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

e Funeral C within 2 To the I the

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State Registrar 29b. Signature and title of certifier

· DHARMASENA

29c. License number

EE STREET

017753

29d. Date signed (Month, Day, Year)

BALTIMORE, MD 21225

and manner stated.

M.D.

purgue, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 1 per doc g91/7-6-11 vt
State of Maryland / Department of Health and Mental Hygiene
amend #5 Per INF G918 8 101/2015 Death 1 - For State Registrar Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 I **Physician** Thomas N. Mayernik 21:50PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore ranklin Square Hospita 9. Birthplace (State or Foreign Country) DA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/27/1927 Age (In vrs. last birthday) **Funeral** Days Hours Min 1**X** M 2□ F 84 PA Director Usual Residence of Decedent show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evancinal must be nefitted at MD Director Baltimore Kingsville 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11710 Bellvue Ave. 21087 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. altimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married à 1 ☐Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public School System Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Mayernik Barbara Stefanik ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea J. Bunting / Daughter 11710 Bellvue Ave., Kingsville, MD 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State 07/07/2011 Grandview Cemetery Monessen, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 phla M01452 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final engestive Heart Physician Fallure disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Acute on chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of): attending physician and for use as the burial-tran Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 1 □Yes 2 □No the detached 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Fibrillation 1 Nes 2 No 3 Probably 4 Unknown icate has been si page 2 should t Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; certificate Diabetes Mellitus Division of Vital 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manyler of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) duna natatoy; 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Danga Doratotal MD.9000 Franklin Square DR. Balto MD

DHMH 17 Rev 1/2001

State

Registrar

0 6 2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Lillian NEEDELMAN Month Year July 2011 9:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Eden House Bethesda 6. Sex 8. Date of Birth (Month, Day, Yea March 31, **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours 1 🗆 M 2 💢 F 578-01-0731 Virginia **Director** Yrs 1916 95 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 28a-f 1 Tes 2 No Marvland Montgomery Potomac 10e. Street and Number 10g. Citizen of What Country?
United States Funeral 23a 10738 Normandie Farm Drive 20854 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Molly Tucker Samuel Barney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10738 Normandie Farm Drive, Potomac, MD 20854 Ron Needelman, Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If it
any injury or of 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Mt. Lebanon Cemetery 07/05/11 Adelphi, MD 21. Signalure of Hundral Say ice Licensee Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. End Stage Dementia Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 χ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Y No 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Living 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) Medical ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and litle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 07/04/11 D 31319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUL 0 6 2011

Loreto S. Albiol, M.D., 8218 Wisconsin Ave., Suite #305, Bethesda, MD

32. Registrar's Signature

20814

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ Wilber 9:25a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Village Baltimore Parkville Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 705-14-0353 1 XM 2 - F Months JUIN 3, YeI 916 West Virginia 95 Director Usual Residence of Decedent 705-14-0353 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified Parkville 28a-f Maryland Baltimore 1 ☐ Yes 2🌠 No 10e. Street and Number ems 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8820 Walther Blvd., #117 South United States "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed Specify: White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygier Engineering <u>Civil</u> Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Wilbur O. Nelson, Sr. Jennie Turner injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Samantha Luckhart/Grand Daughter 609 S. Milton Ave., Baltimore, Maryland 21224 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/07/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 1107 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death theros claros is Coronary Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of ending physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 5 Other (specify) 1 Yes 2 9 Unknown P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I autopsy perform death? 2 🗌 No I ☐ Yes 2 🛣 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 📈 Natural Division 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by tl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check I at the time, date and place, and due to the 29b. Signature and title of certifier HOU 52365 who completed cause of death (Item 23a) (Type, Print). Beltimore, Maryland Konch 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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O. WELSON

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 11:15 **Physician** DU 2011 Dorothy Davis Narbeth /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL NES SAINT Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 15, 1 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 F 1913 New York 98 070-03-0592 Director Usual Residence of Decedent 10d Inside City Limits 10c, City, Town or Location 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f show event, it is Medical Examinat must be notified at 1 ☐ Yes 2 No Catonsville Maryland Baltimore Director the 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21228 United States 709 Maiden Choice Lane permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, it a Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 √ No Specify. White Specify: 3 ₩idowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Butler Klock George Levi Davis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 724 Morningside Dr., Towson, Maryland 21204 Gwen Spicer / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/05/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval Between Onset and Death Immediate Cause (Final DAYS **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as e consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to himme didte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed DEMENTI DOR attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 YNo signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ▼No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD. 00 69177 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 21229

Registrar

State

D AMMAHON 31. Date filed (Month, Day, Year) JUL 0 6 2011

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James J. O'Connor, Jr. Physician/ July 03 2011 6:10 A.M Medical 4b. City, Town, or Location of **Towson** Facility Name (if not institution, give street and num 4a. Facility Name (if not insuluoin, 910 **205 E. Joppa Road** Examiner ^{4c}Baltimore County unit2509 Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day 9. Birthplace (State or Foreign **Funeral** 215-34-5681 74 May 25, 1937 Salisbury, MD. Director Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County at 10c. City, Town or Location Director 28a-f Examiner must be notified 1 🗆 Yes 2 🔁 No Maryland Baltimore County Towson 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States unit2509 23a Funeral 205 E. Joppa Road 21286 items death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc "natural", or ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give 3 Widowed 4 Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) **05** Baltimore City Schools School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James J. O'Connor, Sr. Alice Hokemeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Stiars/ Representative ge 1 and 2 sl it of Health a 1002 Regester Avenue Baltimore, Maryland 21239 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Thursday Parkwood Cemetery 4 Donation 5 Other (Specify) July 07,2011 Parkville, Maryland uneral Service 21. Signature Reaceful Alternatives Funeral and Cremetion Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 23a. Parv1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shack, or heart failure. List only one cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause on each limit of the cause of th Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as alconsequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as Exami that initiated events resulting in death) Last Due to (or as a consed physician s the burial buria Physician/Medical certificate be attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' 1 Yes 242 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director; After 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be the 1 Accident Suicide l in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nutse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed within 2 only one) 29b. Signature and title of certif 6 30. Name and address of person who completed cause of death (Item 23a) JUL 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ju Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laure Battinore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗹 F Months Days Hours Month, Day, Year **Director** Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Private Elementary/Seconday (0-12) College (1-4 or 5+) Electronic SSEMBLES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once, ည William Anderson Page 1 and 2 should be 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keitt 6602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Marylar imonum 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death? vascular disease 24a. Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accider 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29c. License number 0 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of State 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July Pay 2011 3:30 P M Normand Poulin Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase 8100 Connecticut Avenue #1706 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Age (In vrs. last birthday) Days Mar 9, 1926 1 🛛 M 2 🗆 Hours Maine Director 85 006-20-0661 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗌 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20815 8100 Connecticut Avenue #1706 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates.1944-1946 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Central Intelligence Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Operations Officer Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Omer Poulin Florence Poulin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Connecticut Ave #1706 Chevy Chase, MD 20815 Joan Marie Poulin / Wife other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 7/7/2011 Woodbine, Maryland 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final KINSON'S Physician/ DISCASE disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 🗌 No Yes 2 🔀 N 1 🗌 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical pleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 M Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending 1 Tes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the Comple 29b. Signature and title of 29d. Date signed (Month, Day, Year) July 5, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Dennis Cullen,

JUL 0 6 2011

31. Date filed (Month, Day, Year,

MD

MD 20814

7625 Wisconsin Ave Bethesda,

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 4 M JUNE Lecla Dwendolyn Pearson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, 1111 V 18 1 □ M 2 🗓 F Days Hours Min. Year) Country) 579-30-1315 83 **Director** 1927 Virginia Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. must be notified at Director 1 Yes 2 X No MD Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 6402 Randolph Road 20704 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. sant. If item 27 is marked other than "naturury or other traumatic event, the Medical. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Store Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Avon B. Lee Myra Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6600 Manton Way, Suitland, MD Gregory Pearson Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Mem. Park July 6, 2011 Annandale, Virginia 22. Name and Address of Facility Joynes Funeral Home, Inc. 21. Signature of Funeral Service 29 N 3rd Street, Warrenton, VA M01284 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to him rediate cause. Enter Underlying Physician/Medical Examiner igned by the attending physician and be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 5 2 8 1 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 12150 Annapolis Road, Glenn Dale, MD 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander, M. D.

32. Registrar's Signature

Daniel Robert

0 6 2011

31. Date filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. 2

	1- For State Registrar	Certificate	of Death	F	Reg. No	
Physician/ Medical Examiner	Adrian Jerome Perr	<u>-</u>		2. Date of De Month June 23,	Day Year 2011	3. Time of Death 1618 hrs
	4a. Facility Name (if not institution, give street and Prince Georges Hospital Center	Inumber)	4b. City, Town, or Location Cheverly	of Death	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 219-29-9842 6. Sex	7. Age (In yrs. last birthday 23) If Under 1 Year If Und Months Days Hours		irth(MM/DD/YYYY) 9. Bir 0 4 / 1 9 8 7 Foreign	
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
ryland a-f show tonce	MD Prince Geor	ges Upper	Marlboro			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 4516 Bishopmill Dr	rive	10f. Zip Code 20772		10g. Citizen of What Cou USA	ntry?
r death with or items 23 r must be no Funeral	1 Never Married 2 Married Arme	d Forces?	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar	n, Puerto Rican, etc.)	White, etc.	ican Indian, Black,
irs after tural", iminer	Widowed 4 Divorced or Dates: Decedent's Education (Specify only highest or Dates)		Yes 2X No specify.		Specify: B1	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) Colleg	e (1-4 or 5+)	g most of working life. DO NOT Lcist/Produc	ruse retired)	Enterta	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica FO BE COMPILE	17. Father's Name (First, Middle, Last) Antonio Jonathan W		Adr		nise Perry	
e, MD 2121 Land 2 should be fill Health and Mental item 27 it marked r traumatic event,	19a. Informant's Name/Relationship (Type, Print) Adrienne Perry Mot		iling Address (Street and Nur 6 Bishopmil		er Marlbor	o MD20772
10re, Nages I and ages I and ont of Health it: If item other trau	20a. Method of Disposition 1 Burial 2 X Cremation 3 Remove	al from State crematory of	position (Name of cemetery, other place)	Date	20c. Location - City or	
Baltimore, permit Pages I an Department of He. Important: If ite injury or other trees.	4 Donation 5 Other Specify: 21. Signature of uneral Service Licensee	Atlant:	LC Crem 2. Name and Address of Facilit	7/2/11 Simplica	Glen Bur	
	Thomas Alle		ThomasAllenP	A 7090 R	idge RD Ha	nover MD
Physician /Medical	23a. Part I. Enter the disease, or complications the failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple	Gunshot Wounds	er the mode of dying, such as o	cardiac or respiratory ar	rest, snock, or neart	Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or a	as a consequence of):				
niner	cause. Enter Underlying Cause	as a consequence of):				
nted d ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or a d.	as a consequence of):				
tO, e be executed ysician and burial - transit	UNPENDED AMENDE	ED		•		
). Box 68760, the death certificate be executed the attending physician and ched for use as the burial - trapping physician Medical	23b. Was decedent pregnant in the	es, outcome of pregnancy re birth 2 egnant at time of death 5	Fetal death 3 Ectopi	c pregnancy	23d. Date of deliver	y Day Year
Box 64 ne death cert the attendim ned for use a	1 Yes 2 No 9 Unknown 9 Ur	known	Other (Specify)	Loo. Bitt	1	
P.O. res that th signed by be detach	Part II. Other significant conditions contributing	g to death but not resulting in th	ne underlying cause given in Pa		tobacco use contribute to es 2 ✔ No 3 ☐ Prot	
Records, The law requires ficate has been sig page 2 should be Completed				24a. Was	psy prior to o	topsy findings available completion of cause of
tal Rec	25. Was case referred to medical		26.Place of Death	1 ✓ Yes	ormed? death? 2 No 1 Ye	es 2 No
F Vital F Physician: r this certifical director, To Be C	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpati		Nursing Home 5	Residence 6 Othe	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the raper death. 1 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach prification: To Be Completed by P	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ate of Injury path, Day, Year) 3, 2011 1530 hrs	of Injury 28c. Injury at Work	Subject ch	how injury occurred ot	
Division o Biopital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral Certification:	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, farm, s ify) Park/Recreation Are		or Town.	(Street and Number or Ru State) arkway, Temple Hills ,	
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ei	(onour only	best of my knowledge, death or sis of examination and/or invest er stated.				
	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo June 24, 2011	nth, Day, Year)
	30. Name and address of person who completed of Ana Rubio MD. Assistant Medic	ause of death (Item 23a) al Examiner 900 W. B	altimore Street, Baltimo	ore, MD 21223		
State Registrar	31. Date filed (Month, Day, Year) 32	Registrar's Signature	we			
DHMH 17 Rev 1/2001	JUL 4 2 2011	ORIGIN				

11-04484 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 21312

	1	Registrar	ficate of Death		Reg.	No.	The state of the state of
Physicia Medical Examir	n/ ier	1. Decedent's Name (First, Middle,Last) Helen Elizabeth Pittman			2. Date of Death Month D June 14, 201	ay Year 11	3. Time of Death 1939 hrs
		Facility Name (if not institution, give street and number) Stoney Hill Court	Odento			4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 2 1 8 - 2 2 - 8 6 1 4 6. Sex 1 7. Age (In yrs. last 8 3	birthday) If Under Months Yrs.	1 Year If Under 24Hrs Days Hours Min		MM/DD/YYYY) 9. Birt 1928 Foreig Cou	
aryland Sa-f show any at ouce.	ī	MD Anne Arundel Öde	wn or Location enton				10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 516 Stoney Hill Court	10f. Zip Co 2	ode 1113	10g.	Citizen of What Cour	ntry?
hours after death with the Maryland bastural? or items 23a or 28a-f sh Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	If Yes, specify 0	of Hispanic Origin?(Sp Cuban, Mexican, Puerto XNo s <i>pecify:</i>	Rican, etc.)	White, etc.	can Indian, Black, hite
.7	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 2	Sa. Decedent's Usual Oc during most of workin Homemake	ng life. DO NOT use reti	vork done 16 red)	Sb. Kind of Business/li Homema	
	Be	17. Father's Name (First, Middle, Last) UNK		18.Mother's Name	(First, Middle, Maid	den Surname)	
MD 2121 d 2 should be f lith and Mental lith and Tis market numatic event,	٩	Linda Metz Auth Agent		ey Orchar	d Pkwy	Odenton	MD 21113
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		1 Rurial 2 X Cremation 3 Removal from State Crem	ce of Disposition (Name matory or other place) antic Cre	m 7/	2/11	oc. Location - City or Glen Bur	nie MD
	Ŋ	Otham All	Thomas	AllenPA 7	090 Rid	ge Rd Ha	
Physician /Medical Examiner		23a. Pirt I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a consequence of):				snock, or heart	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.					
ecuted and transit	I Examiner	events resulting in death) Last Due to (or as a consequence of): d.					
e be ex	Medical	IF FEMALE: AMENDED 23a, 27, per		-7-11 sm		23d. Date of delivery	
68 certifi nding se as 1	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death	3 Ectopic pregna	incy		ay Year
ires that the d signed by the	≥	Part II. Other significant conditions contributing to death but not resul	iting in the underlying ca	use given in Part I.		cco use contribute to t	
ion of Vital Records, P.O. Box tending Physician: The law requires that the death leath. for: After this certificate has been signed by the arte the funeral director, page 2 should be detached for un	Completed				24a. Was an autopsy performe.	prior to co	opsy findings available ompletion of cause of
ician: s certif	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER	26. VOutpatient 3 DOA	Place of Death (Check of Other, Nursin		sidence 6 🗸 Other:	0
ion of Virtual of the function	tion: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	Bb. Time of Injury 280	: Injury at Work?	g Home 5 Res 28d. Describe how		Scene
Division pptal or Attenditions after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home (Specify)	, farm, street, factory, of	fice building, etc.	28f. Location (Stree or Town, State		al Route Number, City
Divis To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/one and manner stated.					
(4)	Σ	29b. Signature and title of certifier		icense number D.C.M.E.		od. Date signed (Monume 15, 2011	th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a Donna M. Vincenti, MD Assistant Medical Examin	•	nore Street, Baltim	nore, MD 2122	3	
Sta Regist	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	bace				

11-04859 Rosemary Pascol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				Certific	ate of	Death			Reg	No.		
Physicia	ın/	1. Decedent's Name (First, Midd	ile,Last)						1	2. Date of Death Month	Day Yea	r	3. Time of Death
Medical Exami	ner	ROSEMARY	BRO	ΝN	PASC	OL					June 30, 20		,	0928 hrs
		4a. Facility Name (if not institution 5286 Marlboro Pike #	_	street and n	ımber)		4	b. City, Town, o Capitol He		ion of Death		4c. County of Prince G		
Funeral		5. Social Security Number	6. Se	Υ	7 Age (In	yrs. last bii	thday)	If Under 1 Yes		Jnder 24Hrs.	8. Date of Birth		_	
Funeral Director		o. Godiai Geculty Nambol			1. Age (III	•		Months Day	-	ours Min.	1		Foreign	n
Director		291-62-1590	1[_	M 2 X F		51	Yrs.		丄		02-04-1	.960	Col	untry) GA
Any	ŀ	Usual Residence of Decedent 10a. State 10b. County			10c	. City, Towr	or Locatio	on				· · · · · · · ·		10d. Inside City Limits
.		100. 00			1.55	-								1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ġ	MD PRINC 10e. Street and Number	E G	<u>EORGES</u>			CAPIT	OL HEIG	HTS		Lion	011	-10	
Mary r 28a	Director							10f. Zip Code				. Citizen of Wh	at Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.		5286 MARLBORO	PIK					2074				J.S.A.		
or items	Funeral	11. Marital Status 1 Never Married 2 N	larried	12. Was Dec _Armed F		r in U.S.		Decedent of Hi es, specify Cuba				14. Race White		can Indian, Black,
r dea	[교			1X Yes	2	No		v (17)		.,			DT /	OT.
s affe	2	3 Widowed 4 XXDi		If Yes, Give Yes or Dates:				Yes 2 X No			rk dono 1	Specify: 6b, Kind of Bu	BLA	
5-0036 led within 72 hours after tlygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)		College (102.		st of working life				OD. KING OF BU	3111033/11	idustry
36 in 72 than dical	B	12		College (1-70131)	יט	TM A MT	RESOURC	FC	ΛΟΟΤΟΤ	ANT	GOVERN	MENI	יי
1 with	통	17. Father's Name (First, Middle	Last)			111	UTIAN	RESCORC			First, Middle, Ma			
215. be filed mtal Hy riked of	Be										AE BROWN	· ·		
21215-0036 hould be filed within 7 d Mental Hygiene. is marked other than tric event, the Medical		ARTHUR LEE BRO 19a. Informant's Name/Relations	_	/pe, Print)		19	b. Mailing	Address (Stre			ral Route Number		n. State.	Zip Code)
□ sh G	7	LATOYA HOLLOWA			2	9.1					B ALBANY			
more, M Pages 1 and 2 ient of Health int: If item 2		20a. Method of Disposition	1, 10.	10 011111		20b. Place	of Disposit	tion (Name of ce	metery	,		Oc. Location -	_	
Baltimore, permit. Pages I as Department of Her Important: If ite		1 Burial 2 Crematio	_	Removal fr	om State	Ohio crema	tory or other	^{erplace)} rn Rese	rve				~ * * - *	
it. Pa		4 Donation 5 Other S		200]	Natio		emetery ame and Addres		_	2-2011 <i>A</i>	KRON,	OHIC	
Baltimo permit. Page Department Important: injury or ott	1	21. Agriature or Purierar Service	LICETIS				WIL	LIAM C.	BR	OWN CO	MMUNITY	FUNERA	L HO	ME P.A.
Physician	4	23a. Part I. Enter the disease, o	compl	ications that c	aused the	death. Do n	ot enter the	6 W NO	RTH such	AVE.	BALTIMOF espiratory arrest	生,MD shock or hea	<u> </u>	Approximate Interval
Medical	1	failure. List only one cause	on ea	ch line.								,,		Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	-	Oue to (or as a			c Cardio	ovascular Di	sease	•				Death
	- 1		b.	oue to (or as a	Conseque	noe or).								
	ē	Sequentially list conditions, if any, leading to immediate	1	Oue to (or as a	conseque	nce of):								
	힐	cause. Enter Underlying Causa (Disease or injury that initiated	C											
ansit	Examiner	events resulting in death) Last	d.	Due to (or as a	i conseque	nce or):								
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the transport of the result of the transport of	/Medical	UNPENDED		AMENDED									-	
760, ficate be g physic	ğ	IF FEMALE:		23c. If yes,					_			23d. Date of		
687 ertific ding	a l	23b. Was decedent pregnant in t past 12 months?	ne	1 Live b				al death 3	Ect	opic pregnand	СУ	Month	D	ay Year
Box 68; e death certifi the attending ed for use as t	Sic	1 Yes 2 No 9 🗸 Un	known	4 Pregr		ordeath	5 Oth	er (Specify)						
D. B. the de by the	Physician	Part II. Other significant condi				not resultin	or in the un	dedvina cause	aiven i	Part I	23e Did toba	cco use contril	oute to t	he cause of death?
P.O.	6			oo, italiaatii ig	o dodan bar	Tiot rooditii	9	racing reactor	givoirii					ably 4 V Unknown
guires en sig	<u>B</u>										ı 24a. Was an			opsy findings available
cords, law requir has been s	읦										autopsy performe	l p		ompletion of cause of
Rec The L	Completed										1 Yes 2	No 1	Ye:	2 No
tal Recision: The certificate rector, page	B B	25. Was case referred to medica examiner?						26.Place		ath (Check on				
Vit hysici I dire	o١	1 ✓ Yes 2 No	l ^H	ospital: 1	npatient	2 🗌 ER/O	utpatient	3 DOA	Other	Nursing	Home 5 Re	sidence 6 🗸	Other:	Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	اڃَ	27. Manner of Death		28a. Date (Month	of Injury , Day,Year)	28b.	Time of Inj	· _ ·	•	[8d. Describe hov	v injury occurre	d	
tendi leath.	[랿	1 ✓ Natural 5 Pen 2 Accident Inve	ding stigatio	n				1	Yes 2	☐ No				
VIS or Al fifer of Direct in by	읡	3 Suicide 6 Cou	ld not b	e 28e. Plac	e of Injury -	At home, fa	arm, street	, factory, office I	building	, etc. 2	8f. Location (Stre or Town, State		r or Rur	al Route Number, City
Divi	Certification:	4 Homicide	rmined	(Specify)					_			-,		
e Hos											ue to the cause(s			
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Exa		On the basis and manner s	oi examinat tated.	uori and/or i	rivestigatio							
	Σ	29b. Signature and title of certific	er 1	/	15			29c. Licens		ber		9d. Date signe	•	th, Day, Year)
		Allenk	210	ssell	M	\rightarrow		O.C.	M.E.		'	luly 1, 2011		
,	ļ	30. Name and address of person												
		Melissa Brassell, MD	As	sistant Me			900 W.	Baltimore S	Street	, Baltimore	, MD 21223			
	_	31. Date filed (Month, Day, Year)	6	32. Re	egistrar's Si	,								
Regist	EI.	JUL 0 6 2011	Ch.	und.	19. 1	backs	/							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Day 11:12 AM Page-Stack 2011 1. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Davs Hours 84 (Month, Day Yes Director 219-22-9102 1927 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 7 10g. Citizen of What Country? must be Completed by Funeral 23a 21218 3903 Canterbury Rd. United States an "natural", or items Medical Examiner mu filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Medical other t Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r is marked of 2 Page 1 and 2 should be William Allen Sinton, Sr. Elise Baum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a John N. Stack /Son 4402 Wickford Rd. Baltimore, MD 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 듄 Jul 02 ō 1 Burial 2 KCremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 . Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final interctions Physician/ My ocevaria disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death, the Funeral Director: After this certificate has been signed by the attending physicis upleted filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ mast Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Deficiency Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State

Registrar

JUL 0 5 2011

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Petke Rudo1ph 8:20 P M Rene 2011 June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day Months Days Hours Min. 1**XX**M 2 □ F Yrs. Director 52 Dec. 151-58-7830 New Jersey Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Silver Spring Montgomery 1 Yes 2XXNo 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4007 Rickover Rd. 20902 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. 9 þ 1 Never Married 2XX Married Yes, Giv filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify Specify. "natural" 3 Widowed 4 Divorced White Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) giene. **than** " Elementary/Seconday (0-12) College (1-4 or 5+) the Small Business Entrepreneur 4 I Hygiel traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Page 1 and 2 should be Rudolph Petke Regina Basile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine P. Lamont / Wife of Health item 27 4007 Rickover Rd., Silver Spring, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Chesapeake Crematory 07/02/2011 Beltsville, MD MO0382 Rapp runeral and Cremation Services INCU Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) B-CELL LYMPHOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I or Attending Physician; The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicia P.O. Box 68760 cate has been signed by the attending page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No Yes 2XXN 1 Tes **Division of Vital** funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1XXNatural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Funeral Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of qertifier

GEOFFREY COLMAN M.D.,

30. Name and address of person who completed cause of deal (Item 23a) (Type, Print)

29c License number

1355 PICCARD DR. #100, ROCKVILLE, MD

D 37142

29d. Date signed (Month, Day, Year)

20850

JULY 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE 4:25 A M Physician/ A 20 Medical 4b. City, Town, or Location of Death 4a. Eacility Name (if not institution, give street and number) 4c. County of Death **Examiner** 2 OSPITAL <u>un</u>ham 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 □ M 2 🕱 F Months ATasama **Director** or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ¥ Yes 2 □ No Himore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once. SH Funeral Bond 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give 1 ☐ Yes 2 🙀 No Specify. Specify: ack Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Metropolitan College (1-4 or 5+) Elementary/Seconday (0-12) olice Department APTOIN Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ t. MeGinnis UNKnown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Friend) MERECITH C. trevino Terrace, Laurel MD. 11 Gram Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Landover, MD Harmony Memorial 4 Donation 5 Other (Specify) 420 HSt. NE. Name and Address of Facility Signature of Funeral Service Licensee y toneral Home enry Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line Immediate Cause (Final h sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month for Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s performed? Yes 2 No 1 🗌 Yes 2 🗎 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V 8118 Good Luck Road 2Abeth Fasik 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 1/2001

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auren

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Graham

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ORIGINAL

back

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Norma F. Rasinski Physician/ 6 1 7 / 20 1 1 12:20a M Medica 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1366 Andre Street Baltimore N/AAge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) i. Social Security Number 220-14-6122 **Funeral** Days 1 M 2 KF Months Hours 12/28/1925 MD **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD N/A Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 1366 Andre Street 21230 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married ☐ Yes 2 🔀 No Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State Government Payroll Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. Feig Susie Jackson ည Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 349 Grove Park Rd, Baltimore MD 21225 Gloria Ferrin / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 7/2/2011 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Dodnar Testes Funeral Home 1501 E. Fort Avenue, Baltimore 21. Si univere of Four ral Service licensee V1CLOT Inc. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conges Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner alvolar Diseuse Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending obvisician and attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, 1 ☐ Yes 2 Z No 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert C. Dart, 901 E. Fort due. Ral Himare wo

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month; Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aren Ann Robbins	1- For State Certificate of Death	2 3 1
Physician/ ledical Examiner	1 Decedent's Name (First, Middle, Last) Yaron Ann Robbins 2. Date of Death Month Day Year	3. Time of Death 1024 hrs
)	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7918 Bank Street Dundalk 4c. County of Dundalk	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 8/9/66	9. Birthplace (State or oreign MD Country)
faryland 128a-f show any 1at once.	Usual Residence of Decedent 10a. State 10b. County MD N/A 10c. City, Town or Location Baltimore City	10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 7918 Bank Street 10f. Zip Code 21224	Country? USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at nace To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year 1 Yes No specify: Specify:	white
5-0036 ed within 72 hours a tygiene frame "natura the Medical Exami		ervice
21215-0036 uld be filed within 7 Mental Hygiene. marked other thas ic event, the Medica FO BE Comple	Catherman Geneva	Tudor
MD 21 tid 2 should tith and Me m 27 is ma aumatic co	Amanda L. Pollard /Daughter 1642 Beason Street, Baltimos	re MD 21230
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra	4 Donation 5 Other Specify:	er Maryland
Physician Physician	21. Signature of Funeral Service Licensee Victor P. Dod Charles L. Stevens Funeral 1 1501 E. Fort Avenue, Baltimos 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	re MD 21230 Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined drug(Zolpidem and Buprenorphine) Intoxication Due to (or as a consequence of):	Between Dnset and Death
190	Sequentially list conditions, b.	
ed nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause c. Due to (or as a consequence of):	
be executed be executed sician and nurial - transit	d. ☐ AMENDED 23a,27,28a-f,per me,g919 9-8-11 sm	
ion of Vital Records, P.O. Box 68760, teodiog Physiciae: The law requires that the death certificate beath. For: After this certificate has been signed by the attending physic the funeral director, page 2 should be detached for use as the bur attent. To Be Completed by Physician/Mec	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) 9 Unknown	Day Year
ires that the d signed by the lbe detached		te to the cause of death? Probably 4 ✓ Unknown
Division of Vital Records, P.C tal or Atteoding Physiciae: The law requires that its after death. *In Director: After this certificate has been signed led in by the funeral director, page 2 should be determined on the funeral director.	24a. Was an autopsy pringer der 1 ✓ Yes 2 No 1 1	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital Rec ysiciae: The his certificate director, page	25. Was case referred to medical 25. Place of Death (Check Only Only) Whospital: 4 Inspiral 3 DOA Other Nursing Home 5 Residence 6	Other: Scene
n of Vi diog Physi I. After this funeral dir	77 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred	
Vis or At or At Direc in by	Natural 2 Accident Accide	
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and place, and due one) 2 Sobrature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed	s stated. e to the cause(s)
H × H × D	OGME	(Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	
(1)	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

Please Type or Print in: Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ 30 150N ELORES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PIKESVILLE BAUTIMORE VICCE 208 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Country) Hours Yrs. **Director** 28a-f shov 10b. County 10c. City, Town or Location at 10a. State 10d. Inside City Limits Director Baltimore Examiner must be notified Owinas 1 Yes 2 No 9 10e, Street and Number of. Zip Code 10g. Citizen of What Country? 23a Funeral 21117 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 ₩idowed 4 □ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County eachev 2tharade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Williams gernude Cook annon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Winding Brook Road Bordentown, NJ 08505 lanine) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Ratimore, MD 07/2011 Greenmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) Greene Pluveral Service 21. Signature of Funeral Service Licensee 22. Name and Address - acility ndallstown MD 21133 Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause Einal anveance Carrinom h, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phone that the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No Unknown t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 nknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has I in by the funeral director, page 2 s autopsy death? 2 🗌 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DQA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: Natural 28c. Injury at 28d. Describe how injury occurred Hospital or Attending iniury Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I 29d. Date signed (Month, Day, Year) Vaymord Mitte 6 1047683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARC IA ROTHSTEIN 2011 01:15А м JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ENVOY OF PIKESVILLE **BALTIMORE** PIKESVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 M 2XX Days 07/16/1927 Min. 83 Director 218-28-7447 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2503 VELVET VALLEY WAY 21117 USA death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME **HOMEMAKER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ZURIFF CLARA BENDER NATHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health s Important: If item 27 is any injury or other tra KAREN TEPLITZKY/DAUGHTER SAXONY COURT. BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH JACOB CEMETERY 107/03/2011 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin and-tran Due to (or as a consequence of) burial attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 2 No 1 🗌 Yes Yes 2 the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital 2 No 은 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles St. Svite 4105. Touson MD 21204 6701 31. Date filed (Morkh, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 3, 2011 VERONTKA ELIZABETH RUDENSKY 3:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Essex Riverview Rehabilitaion Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 01/12/1937 Germany 220-36-2002 74 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director Maryland 1 Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 1 Eastern Blvd 21221 Germany 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emil Jacob Elizabeth Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Rudensky Son 307 S. Ann St. Baltimore, Maryland 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Holy Cross Cemetery 07/07/2011 Glen Burnie, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 0575 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exacts.) Examine oue to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No es mellitus 24a. Was an cate has by page 2 s autopsy r this certificate haral director, page Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗆 Yes 2 -HO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 Natural work?
1 Yes 2 No _____ ivatural
☐ Accident
☐ Suicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ← Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/5/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's signature

21221

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Charles Szymanski 2011 4:29a July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Birthpiec Country) MD 8. Date of Birth **Funeral** Days Hours (Month, Day, Ye 59 **Director** 216-60-5931 195 Usual Residence of Decedent show 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Westminster Carroll MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21157 801 Velvet Run Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White etc Yes 2 No Yes, Give 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify "natural", 3 Divorced 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) telecommunications College (1-4 or 5+) cable splicer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Imogene F. Thomas Konstanley W. Szymanski permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Velvet Run Dr., Westminster, MD 21157 Stephanie Szymanski (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-6-11 Sykesville, MD All County Cremation Signature of Funeral Service License 22. Name and Address of FacilityHaight Funeral Home & Chapel Parge Harght 3 195 Sykesville, Box 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
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Onset and Death shock, or heart failure. List only one cause on ath lin-Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consecutional of) if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 3611 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p Rocha 4231 Trail State

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Registrar

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State 31. Date filed (Month, Day, Year) 32. Registrar Signiture			Stevensle Boggershuster	nu	2her	red hen	u Sul	2420	1 werent		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** 8102AMM Prine ervari 20 U /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 4/14/42 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X 69 218-40-1735 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show aţ 1 XYes 2 ☐ No Director other traumatic event, the Medical Examiner must be notified Baltimore MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Apt. B-3 USA 21218 "natural", or Items 23a 3902 Canterbury Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black. White, etc. hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>م</u> If Yes. Give 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hair Salon 12 Owner h and Mental Hygier 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 1 and 2 should be Lillian E. Siegrist Richard M. Cook Owens ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a ant; If item 27 is Eugene A. Servary / Husband 3902 Canterbury Road Apt. B-3 Baltimore, Md. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important; If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 17/7/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 _ mplications that caused the death. 23a. Part 1. Enter the disease, or shock, or heart failure. List, Do not enter the mode of dying, such as cardiac or respiratory arrest, v one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner tempeloid leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exacts.) Examiner burial-transit 199 - 5ma that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760, Physician/Medical death certificate be use as the IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 - Fetal death 3 Ectopic pregnancy þ Month Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has 2 No this certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 Nnpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ the funeral 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 Tes 2 No ☐ Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State)

P.O. of Vital Records, al or Attending Plas after death. Division To the Hospital within 24 hours a To the Funeral C completely filled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature JUL 0 6 2011

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Pauline Amanda Schaffer Day 1:35P 30 2011 Medical June Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Village <u>Parkville</u> Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1917 1 M 2 TF Months Hours 93 **Director** 220-38-9039 Indiana Usual Residence of Decedent should be filed within /z nouse and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show reaumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland **Baltimore** Parkville 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3020 Lavender Avenue 21234 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ð 1 Never Married 2 Married Yes, Give 1 ☐ Yes 2 🔽 No Specify 3 XWidowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. 2 William Luetkemeier Emelia Schaefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Schaffer (Son) 3020 Lavender Avenue Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State July 06, 2011 4 Donation 5 Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Cremation

8800 Harford Road Parkville N

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real failure. List only one cause on each line. Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Due to (or as a consequence of): √Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Lindarying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiovaxulos Disease, CHF, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, [To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural injury 5 \square Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and minimal as stated.
3 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 6/30/2011 R171944 10 mpleted cause of death (Item 23a) (Type, Print) GHarison Care 8800 Walther Blvd, Parkville, MO 21234 JUL 0 6 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

130

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 $\mathbf{J}_{\mathbf{u}}^{\mathsf{Month}}$ 8:35 PM Margaret Rogers Sappington Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Columbia Howard If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Year) 1921 1 M 2 X F Days Hours sept 2, Marvland Director 212-26-2231 89 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Tyes 2 X No Columbia Maryland Howard ò 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 21044 United States 6117 Sebring Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Coleman Rogers Margaret Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan R. Hill / Son 6117 Sebring Dr. Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/6/2011 Woodbine, Maryland 21. Sign fure of Funeral Service vicens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ pneumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 lung disease, cardiomyopath Division of Vital Records, 2XNo 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The 124 hours after death.
Funeral Director; After this certificate h perforn 2 🗆 No Yes 2 No 1 Tes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one) 29c. License numbe မ 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Codarlane Columbia MD

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 7:00 AM 05 Juanita Rache1 Stallings | 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel FutureCare Chesapeake Arno1d If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🖾 F 89 216-44-9611 Director 01/28/1922 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanciant is ust be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director MD Anne Arundel Arnold 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21012 by Funeral Baybourne Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★No 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 24 TxNo Specify 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Job Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer S. Stallings Lyda R. Jubb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arnold, Maryland 21012 Ms. Sarah A. Davies / sister 190 Baybourne Drive, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 07/08/2011 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, MD 22. Name and Address of Facility 1 2nd Ave, SW 21. Signature of Funeral Service Licenses Glen Burnie, MD Mo1357 | Singleton Funeral & Cremation Services, 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearth. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Demente Vera 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Error I parties. Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Box 68760, 🛠 burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐ Yes 2 🔀 0 of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Division Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No death. Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 86 OI Veterans Hay, (Month Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Z 36 AM Donald Newton Shibler Medical 06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Meritus Health Hagerstown Washington Social Security Number Month, Da, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Maryland **Director** 213-46-6383 Ĩ947 May Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 26 Schoolhouse Court 21713 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces 0 Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Security Guard</u> Retail Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Robert Earl Shibler Margaret Louise Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 4108 Sir Walter Rd. Olney, MD 20832 Dean Edward Shibler/son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 07/02/11 Woodbine, MD 21. Signature of Funeral Sprice Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the delease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DUODENM - 9m PHOM A disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DUODEMAL if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Month Day Year Yes 2 No 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.

Funeral Director: After this certificate has Leen signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEPSIS - SEVERE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown MULTI ORGAN FATURE SYMIPOME 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 s autopsy performe Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗀 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioners To the best of my knowledge 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) D069946 endro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emeric Palmer, M.D. 11116 Medical Campus Rd. Hagerstown, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JUL 0** 6 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 10:30 PM ham Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death ellel mery nec monigomen If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) Year 9. Birthplace (State of Foreign **Funeral** 8. Date of Birth 24 Days 668 1 M 2 D F Min Director Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director montgomen MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: i Duite If Yes, Give 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stockbroker Stocks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Gerstein ၉ Harry B. Sperling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Sperling, Wife 713 Northwood Terrace, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lebanon Cemetery 107/05/11 Adelphi, MD 4 Donation 5 Other (Specify) Sign ture of Funeral \$6 Torchinsky Hebrew Funeral Home Carroll St., NW, Washington, 20012 23a. Part 1. See the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final neumonia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner lu monary 055 metive Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year isigned by the a 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 **Y**N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖪 No Hospital: Other: ၉ 🗂 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 \square Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/2011 MAINNO 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

605 1Avo Rivero, M.D., 18101 Prince Philip Dr., 01ney, MD 20832

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Saffer Physician/ Month John Daniel 3: 23 A M 29 June 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Lighthouse Assisted Living Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 DXM 2 D F 89 April 1922 Country) 215-22-4994 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 🗆 Yes 2 🎽 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 1813 Old Eastern Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced WWII Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Marie Stoutter John Saffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6803 Youngstown Rd., Dundalk, MD 21222 Joseph Bandzolek - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crematory 6-30-11 1 Burial 2 XCremation 3 Removal from State Glen BUrnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice and 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ENd-Stage Onset and Death Parkinsons Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performee death? 2 🗌 No Yes 2 No 1 🗌 Yes ours after death.

eral Director. After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Pacify 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) MSSkjapabren.D 6/29/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 5-703 N.S. Rajapakumo 2835 Smin AV

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **JUL 0 6 2011**

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death M97/3/2011 Physician/ 12:13 P M Carlton Stem Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth g. Birthplace (State or Foreign Country) MD **Funeral** 1**XX**M 2 □ Y073071927 213-24-9303 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10b. County 10a. State the Maryland at Director items 23a or 28a-f s ner must be notified 1 Yes 2 K No Sykesville Carroll 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." USA 21784 6514 Freedom Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No 1 ☐ Yes 2X No Specify If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Vehicle Operator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nellie Virginia Duvall John Wesley Stem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Peeling/Daughter 720 Norfield Ct., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ebenezer UMC Cemetery 7/8/2011 Sykesville, MD 21. Signatu e d Funeral Service Licensee 22 Burrier Queen Funeral Home & Crematory, P.A. Cernu4 1212 W. Old Liberty Rd., Winfield, MD 21784 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Enter the disease, or complications that, or heart failure. List only one cause on Approximate Interval Between Onset and Death RRHUSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to for as a conscenimos of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for 2 No g 🗌 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an iis certificate has director, page 2 autopsy performed 1 Yes 2 No 1 🗌 Yes 2 100 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: NYATIEN 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Accident injury 1 Natural 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only of 29d. Date signed (Month, Day, Year) 29b. Signat and title of certifi

State Registrar 31. Date filed (Month, Day, Year)

0 6 2011

6

completed cause of death (Item 23a) (Type, Print)

		1	For State State Registrar	of Maryland		tificate of L			Reg. No.	
Physic	cian		Decedent's Name (First, Middle, Last)				<u> </u>	2. Date of De	ath	3. Time of Death
	dica	al _	Aa. Facility Name (if not institution, give street and nu	mber)		4b. City, Town, or	Location of Deatl	Month	Day 2 Ye 26 20 4c. County of I	
			Harbor Hospi				ltimon		N/A	
Funer Direct	_	1	5. Social Security Number 215 70 3460 6. Sex 1 1 1 1 M M 2 1 F	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08/30	7/1957	Birthplace (State or Foreign Country) Maryland
ind show at		- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
Maryla 28a-f		Director	Maryland N/A	F	Baltim					1 🕱 Yes 2 🗆 No
with the	1	Funeral D	10e. Street and Number 100 Pontiac Avenue			10f. Zip Code	21225		10g. Citizen of Wha	it Gountry?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		<u>ا ج</u>	Armed F	2 🗶 No ive	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 👿 No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
15-0 72 hou n "natu ledical		Completed	15. Decedent's Education (Specify only highest grade complete		(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most of wor	rking	16b. Kind of Busin	ess Industry
within /giene.			Elementary/Seconday (0-12) College 12th	(1-4 or 5+)		redore			Grain E	levator
land be filed ental Hy ked ott		To Be	17. Father's Name <i>(First, Middle, Last)</i> John W. Sr	mith Sr.				me (First, Middle, :lia A. (Maiden Surname) Goddard	
, Maryland 21215-0036 d 2 should be filed within 72 hours after alth and Mental Hygiene. n 27 is marked other than "natural", o er traumatic event, the Medical Exam		Ì	19a. Informant's Name/Relationship (Type, Print) Denise Smith / Wife			g Address (Street Pontiac A			er, City or Town, State	e, Zip Code) aryland 21225
ge 1 ann tof He it if iten			20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal fro	m State cen	netery, crem	sition (Name of natory or other plac	106/	Date 29/2011	20c. Location - Cit	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	ouce.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun (Service Licensee)	Вауч		rematory Name and Addre		once Fun	eral Serv	e, Maryland
a = = = = =	ō	-	23a Part 1 Enter the disease or complications that	t caused the death	4	001 Ritcl	nie Highv	vay Ba	ltimore, i	Maryland 21225 Approximate
- Physicia Medic			23a. Part 1. Enter the assease, or complications that shock, or heart failure. List only one cause on disease or condition resulting in death)	Juite 6. Juite 6. Joras a consequent Jud Stage	astro	In testina	l bleedi	rs.		Interval Between Onset and Death UNknown
Examin	er		Sequentially list conditions, b.	ond Stare	liver	disease	2 .			Unknown
sit ed ()	7	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	(or as a consequen	noc oij.					
760 (cate be executed physician and the burial-transition)		EXa	that initiated events c.	o (or as a conseque	nce of):					
760 icate be physic s the bu		edical	d		···					
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as			in the past 12 months?	utcome of pregnance Birth 2 Fetal o gnant at time of dea known	death 3	Ectopic pregnand Other (specify)	су		23d. Date o Month	1
IS, P.O. Lires that the signed by all be detact		2	Part II. Other significant conditions contributing to	death but not resulf	ting in the u	nderlying cause g i	ven in Part I.			te to the cause of death?
Record The law req ate has bee		Completed						24a. Was auto perfo 1 \sum Yes	psy prio prmed? dea	re autopsy findings available r to completion of cause of th?
ician: certifica		Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Oth	lace of Death (Che	, ,		
n of V ding Phys th. After this		cate: To	27. Manner of Death 28a. Dat	e of injury 2 Denth, Day, Year)	R/Outpatien 8b. Time of injury	28c. Injur	4		dence 6 Other (S	Specify)
Division all or Attents after dear I Directors of in by the		Certificate:	3 Suicide 6 Could not be	ce of Injury - At hom ding, etc. (Specify)	e, farm, stre			28f. Location (City or Tou		r Rural Route Number,
he Hospita in 24 hours he Funera pleted fille		Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the control of the control of the control one) 1 Certifying Nurse Practione	asis of examination a	and/or invest	igation, in my opini	on, death occurred	at the time, date a	and place, and due to	the cause(s) and manner stated
To t			29b. Signature and title of certifier			29c. Licens	e number	,	29d. Date signed (A	
4			30. Name and address of person who completed ca VOLENNELD PERCY	use of death (Item 2	13a) (Type, P	(rint)				21 225
	State stra	9	31. Date filed (Month, Day, Year) 32.	Registrar's Signatur				-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 21334 State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	n Waryland /		ficate o		ina montan		Reg. No.		
Physiciar Medical Examin	n/	Decedent's Name (First, Middle,Last)		Fred	erick	Simpkin	ıs	2. Date of Dea Month June 25,	Day	Year	3. Time of Death 2242 hrs
		4a. Facility Name (if not institution, give Harbor Hospital	street and number)			4b. City, Town, o	or Location of Dea	ath		nty of Death	
Funeral Director		5. Social Security Number 6. Sex 1219 21 1810		(In yrs. last	t birthday) Yrs	If Under 1 Ye Months Da		8. Date of B lin. 03/1		YYY) 9. Birti Foreign	
Maryland 28a-f show any d. at once.	ļ	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		•	own or Locat Balti	more					10d. Inside City Limits 1 X Yes 2 No
with the Maryland na 23a or 28a-f aho be notified at once.	Director	10e. Street and Number 3835 - 10th Str	eet			10f. Zip Code 21	225		10g. Citizen o	S.A.	try?
er death	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		Ever in U.S.	If Y		Hispanic Origin? (an, Mexican, Puer lo specify:			Vhite, etc.	an Indian, Black,
2 -	Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 12th	or Dates:		6a. Deceder during m	it's Usual Occup	pation (Give kind of fe. DO NOT use re		16b. Kind o	fBusiness/Ir	•
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	æ		William F	rederi			18.Mother's Nar	ne (First, Middle, loria So		ame)	
trie is de la la la la la la la la la la la la la	₽[19a. Informant's Name/Relationship (Typ Gloria Simpkins				Address (Stro	eet and Number o Street				zip Code) and 21225
Baltimore, MC permit. Pages 1 and 2 st Importment of Health an Important: If item 27 injury or other transma		20a. Method of Disposition 1 Burial 2 A Cremation 3 4 Donation 5 Other Specify:		е сге	matory or ot view C	remator	у 07		l Bali		, Maryland
		21. Signature of Funeral Service License			4(001 Rito	ss of Facility (chie High	nway Ba	ltimore	e, Mar	yland 21225
Physician Medical Examiner	4			Intox					rest, shock, or	heart	Approximate Interval Between Onset and Death
	<u> </u>	cause. Enter Underlying Couse c.	ue to (or as a consec								
Transit ransit		events resulting in death) Last Di	ue to (or as a consec								
760, (crate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED 23a,			er me,g9	17 7-14 -	ll sm	23d Dat	e of delivery	
Box 687(e death certifica the attending ple ed for use as the	Physician/	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at ti		2 Fe	tal death 3 her (Specify)	Ectopic preg	nancy	Mont		ay Year
P.O. s that the gned by e detach	6	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	inderlying cause	given in Part I.				he cause of death?
aw requi	Completed							24a. Was auto perfo 1 Yes	psy orm <u>ed</u> ?		opsy findings available ompletion of cause of S
Vital Rechysician: The Ithis certificate I director, page	o Re	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatien	t 2 🗸 EF	R/Outpatient		Other Nurs	k only one) sing Home 5	Residence	6 Other:	
ion of variation of by teath. tor: After the funeral of the funer	- 1	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yei	ar)	8b. Time of I	1	ury at Work?	28d. Describe Unknown	how injury oc		
Divisi ital or Att urs after de ral Directu lled in by	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined	28e. Place of Inju		e, farm, stre		building, etc.	28f. Location (or Town, Baltime	State) 383 ^t	5 10th	al Route Number, City
0 - 3 >	ल्	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: 0	n: To the best of my	knowledge,	death occur			nd due to the cau	se(s) and mar	ner as state	
	Ĭ	29b. Signature end title of certifier	lalla	il			se number .M.E.		29d. Date s June 26		th, Day, Year)
\mathscr{D}		30. Name and address of person who co Carol Allan, MD Assistan	mpleted cause of de t Medical Exam		,	imore Stree	t, Baltimore, I	MD 21223			
Sta Registra	_	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	nes					-	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 01 SAMUEL SIGLER JULY 4:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** 1 M M 2 □ F Days Hours Min (Month, Day, Year) 11/12/1914 Months Yrs **Director** CANADA 212-01-0080 96 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 7121 PARK HEIGHTS AVENUE, #403 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify: Specify 3 Divorced 4 Divorced Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working INTERNAL life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) ACCOUNTANT REVENUE SERVICE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 HARRIS SIGLER SARAH BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. ERMA SIGLER/WIFE 7121 PARK HEIGHTS AVENUE, #403, BALTIMORE, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) SHALOM MEM. PK. 107/03/2011 REISTERSTOWN, MD 21. Signature of Fu 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 ☐ Other (specify) Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? ၉ 2 1000 Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 N Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST Tonson MON 6701 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day 2011 SCHREIBER JUNE 30

1 - State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 6:35 PM LIBBY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5800 NICHOLSON LANE, MONTGOMERY ROCKVILLE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. 10/31/1915 Director 213-42-6353 95 MD Usual Residence of Decedent show 10a. State ms 23a or 28a-f sho must be notified at 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5800 NICHOLSON LANE, 20852 "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced WHITE Year or Dates nd Mental Hygiene. marked other than "natur matic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALESPERSON RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ other traumatic MOSES TRIVAS MOLLY ADLER is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Health tem 27 MARYELLEN STEIN/DAUGHTER B100 N LEISUREWORLD BLVD, #608, SILVER SPRING, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHAAREI TFILOH CEM. 07/04/2011 BALTIMORE, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death MONTHS Ph_{sician} METASTATIC COLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death signed by the a 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADVANCED AGE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? CORONARY HEART DISEASE 24a. Was an autopsy performed? Yes 2 X No certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 🗓 No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) JOHN GALOTTO 5225 POOKS HILL ROAD, SUITE 1-A, BETHESDA, MD M.D., 20814

State Registrar 31. Date filed (Month, Day,

0 6 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02 Day Physician/ JULY 2011 12:05 AM **EVAN** S SCHECHTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A 5908 BLAND AVENUE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 XM 2 □ F Months Hours 1070571947 118-38-1082 63 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD N/A BALTIMORE 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 21215 USA 5908 BLAND AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. Yes 2 XNo ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify WHITE "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) SOCIAL SECURITY Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 5+ STATISTICIAN ADMINISTRATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ARTHUR **SCHECHTER** VIVIAN BRENGLASS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARGARET SCHECHTER/WIFE 5908 BLAND AVENUE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/03/2011 AGUDATH ISRAEL CEM BALTIMORE, MD 4 Donation 5 Other (Specify) of Funeral Service Li 22. Name and Address of Facility Sign SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part . Enter the disease, or complication. ... shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final ANCRIATIC Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? for Month Year Day Pregnant at time of death 2 No signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown been signature 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No director, 26. Place of Death (Check only one) 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) ည 1 Inpatient 2 I ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 2 □ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After Natural 5 Pending thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one 29c. License numbe 29b. Signature 5039 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print) BALTINONS 2/209 2835 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Jun 25, 2011 Year Julia Flora Sablowski 12:38 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Gilchrist Center Howard County Columbia Social Security Number 8. Date of Birth (Month, Day Year) Nov 16, 1924 Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours 1 M 2 213-20-1812 Marylan Yrs **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified MD Elkridge Howard 1 🗆 Yes 2 No 10e Street and Number 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 23a 5820 Old Hunt Club Rd. 21075 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc ò þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. "natural" 3 ☐Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done uning life. DO NOT use retired)

Cook (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **Food Service** event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herman Kramer II Julia Corona Fiedler other traumatic Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5820 Old Hunt Club Rd. Elkridge, MD 21075 Department of Health a Important: If item 27 is any injury or other trains Jean M. Sablowski Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Jul 01, 2011 Elkridge, Maryland Meadowridge Memorial Park, 4 Donation 5 Other (Specify) 22. Name Stack Führerar Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 lunulle MO053 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death ediate Cause (Final Ph sician/ dispase or condition nomen Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Que to (or as a consequence of): burial-transi 115homes that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 EBICAL EXAM 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death CEMESCELLON WAS BUSINED BY 23b. Was decedent pregnant Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn 2 🗆 No After this certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 2. Accident injury 5 Pending work? 2 No Fall in both war Investigation -8-0-<u>untrowi</u> the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5500 Old Hunt Club 2d 4 Homicide completed filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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Love Countre

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\overset{ ext{Month}}{ ext{July}}$ Day 2011 Wyatt Cameron Slack 4:04 P. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Gilchrist Towson Baltimore Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Unde **Funeral** 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Hours Min 1 X M 2 □ F 1928 **Director** 216-24-7393 83 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 🗆 Yes 2 🔀 No Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code 23a Funeral 1055 W. Joppa Road 21204 U.S.A items (Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 \$\overline{\text{V}}\$ Yes 2 \subseteq No If Yes, Give Year or Dates.1950-1958 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status "natural", or ite Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 □ Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years Banker Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richmond Slack, Jr. Elizabeth Blanchard Randall 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr Randall Dyer Slack (son) 220 E. 73rd. St. Apt. 3F New York, New York 10021 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 7-5-11 Baltimore, Maryland Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary Perranse 21212 23a. Part 1. In ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis with respiratory Failur y ndrome weeks disease or condition Medical resulting in death) Due to (or * a consequence of Examiner cholongitis cute RRKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death ed by the detached 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 24 hours after death.

Funeral Director: After this certificate I Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Dice within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral! 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of home 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) Charles St.

DHMH 17 Rev 7/2009

State Registrar e filed (Month, Day, Year)
0 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ CAMMAHOM SOLEIMANPOUR 2011 JULY 1:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6 Jonathans Court Cockeysville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**XX** M 2 □ F 10/04/1923^{ar)} Iran 87 215-37-3894 Director Usual Residence of Deceden 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director Maryland Baltimore Cockeysville 1 Tes 2 XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6 Jonathans Court 21030 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Examiner Armed Forces?

1 Yes 2 XX ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: white "natural", Completed 3XX Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+)
5+ Elementary/Seconday (0-12) Judge/ Physician Law/ Medical other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hossein Soleimanpour Nosrat Parto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is any injury or other traumonce. Sudi Soleimanpour 6 Jonathans Court Cockeysville, Maryland 21030 20a. Method of Disposition

Wal Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Dulaney Valley Mem. Gardens 07/05/2011 |Timonium, Maryland 21093 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John 0. Mitchell, IV Funeral Services of 21. Signature of Funeral Service Licensee Dulaney Valley, PA 200 E. Padonia Road Timonium, MD 21093 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, struck, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Physician/ Strag disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE SEMALE: be detached for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Dav Month Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by recurer 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title and address of person who completed cause of eath (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death MARSHALL TISDALE-JONES Month 07 - 02 Day 20 11 Physician/ 11:50PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN NURSING CENTER BALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) VA 1 □ M 2 🔀 F 90 Yrs. Months (Month, Day, Year) 04-23-192 Director 215-24-6333 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 531 WILLOW AVENUE 21212 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r DOMESTIC Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPER injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ButtERWORTH EMMA ALLEN permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COOPER DAUghter 3244 KELOX RD. BALTIMORE, MD. 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State HOLLY HILLS CEMETERY 9/2011 BATTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen ice Licensee 22. Name and Address of Facility VAUEHN GREENE FUNERAL SCVS, PA MI 4905 YORK ROAD. BATTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Vascular Immediate Cause (Final Onset and Death erebr. Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has t autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No မ ER/Outpatient 3 DOA 1 🔲 Inpatient 2 🔲 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred he Hospital or Attending Ponts after death.

Funeral Director; After the Funeral Director; After the funeral filled in by the funeral places. Certificate: ■ Natural 5 Pending work? 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D58570 5601 Loch Rava 30. Name and address of person who completed cause of deg 0 CAPANCE 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ident's Name (First, Middle, Last) 2. Date of Death Physician/ 1:00pMedical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7885 Gordon Court Apt Glen Burnie Anne Arundel 580 Social Security Number 215-80-3402 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs 51 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Days Min. Hours 06/19/ MD **Director** ′T960 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21060 7885 Gordon Court Apt 580 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Teal Pauline Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 428 Pine Terrace Glen Burnie MD 21061 Kathy Harrison Sister 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 6/24/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of puneral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death for in the past 12 months? Month Pregnant at time of death 2 No detached the ģ been signed I should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was an 24a page 2 s has autopsy performed 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 I Nursing Home Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Marmer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred Natural Accident injury 5 Pending 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier ctifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ctifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ertifie 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year State 6 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edith Evelyn Van Duzer 03:55 A^M July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 035 Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov 1, 19 Months Days Hours Min. Director 1918 Washington. 578-12-6522 Usual Residence of Decedent or 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Wheaton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4202 Elby Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: White 3 Widowed 4X Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Officer Federal Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Scott Trammell Edith Rose Riedl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau B.L. Van Duzer 516 Hollyberry Way Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 07/07/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Lige 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio pic/monary
Due to (or as a consequence of): Ph_sician/ arrest disease or condition resulting in death) Medical **Examiner** sepsis Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury aspiration pneumonia and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 98 IF FEMALE: use a 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by do thrive Chronic obstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Yes 2 No certificate has page colecton partial 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Hospital or Attending 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 69/48 И ss of person who completed cause of death (Item 23a) (Type, Print) Rochville Mata MD 10110 Molecular Dr Suite 2 Mar, chu 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 7 4:13 AM Fait Wright Medical 4a. Facility Name (if not institution, give street and number) 5601 Lock 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Hospital Raven Bivd Baltimore, MD 21239 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 75 218-40-1463 VA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumante event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Baltimore 1 X Yes 2 No 10e. Street and Number Hourbors ide Harford G 10f. Zip Code 10g. Citizen of What Country? USA 4700 Harford Road 21214 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ₺ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEKEEPER HILTON HOTEL Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည THOMAS **VAUGHN** MARY BELL ALEXANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. MADISON STREET, BALTIMORE, MD 21205 PHYLLIS JONES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FIRST BAPT. C. CEM 07/09/11 LAWRENCEVILLE, VA 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC ai 1701 LAURENS ST., BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic heart disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or finjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🗶 No Month Year Dav Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes 2 ↓ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypertension, COPD, 1 Yes 2 No 3 Probably 4 Unknown stroke, dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed 25. Was case referred to medical examiner?
1 X Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending N/A NIA Accident Investigation after death Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0069251 7/5/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Terina Chen MD 5601 Loch Rowen Blvd Baltimore, MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 3. Time of Death Physician/ Woolridge 1235 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore VA Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** XM 2 □ F Min. Months Days Hours (Month, Day, Year) 4 / 1 4 / 4 5 216-42-6615 Director 66 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD N/A Baltimore 1 XXes 2 □ No 10f. Zip Code ō 10g. Citizen of What Country? Woodyear Street 21223 23a Funeral USA items ; hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Army
Armed Forces? Army
1 🖾 🔀 2 🗆 No.
Give Vietnam 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black White etc. o, ò 1 XNever Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: White "natural", 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Ith and Mental Hygiene.
27 is marked other than "r traumatic event, the Med within 72 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Loader Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Hubert C. Woolridge, Sr. Anna Keene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21 327 S. Woodyear Street, Baltimore MD 21223 19a. Informant's Name/Relationship (Type, Print) Catherine Pesayco /Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Ardent Crematory 6/29/201|1 Hanover MD ■ Donation 5 ☐ Other (Specify) Licensee Victor gnature of Fun Doda es L. Stevens Funeral Home, Inc. E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initiary that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ast IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate ! 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No ျှ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury after death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) n 24 hours a e Funeral I Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) M.D 06-24-2011 843712 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Dong

X Jaobo Dol 31. Date filed (Month, Day, Year) M. O.

N.

10

Greene St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Jime of Death Date of Death Physician/ Medical **Examiner** or Location of Death 4c. County of Death Himore If Under 24 Hrs Date of Birth Birthplace (State or Foreign Country) **Funeral** 9 25 1920 M 2 □ F Months Hours Min. Director NC 23a or 28a-f show City, Town or Location 10a. State traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director atonsville MD Hmore 1 Yes 2 No 10e. Street and Numb 10g. Citizen of What Country? Funeral 5906 2/228 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Specify: Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify. If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education cify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Il Hygiene. onday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the Be permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State nosimbe 4 Donation 5 Other (Specify) 21. Sig. aure of Funera Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death
YEALS "Physician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to him could cause. Enter Underlying Examine Dust to (or as a consequence or): ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 performed? Yes 2 No the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner' Other: 2 **N**o မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature vall 031136 use of death (Item 23a) (Type, Print) W. BELVEDERE AV. State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 6

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	_	For State Registrar		Sia	te or ivi	iaryiari			tment of I ficate of I		anu iv	rentari		. No.?		2 1	31.7
Physicia		1. Decedent's Name	1 /	Last) icha	01	(1)0	5.4	-				2. Date of		Day	Year		ne of Death
Medic Examin		4a. Facility Name (if	- / -	11.00		n'er	- 11		4b. City, Town, o	r Location	of Death	<u> </u>	ी	4c. Count	y of Death	1	
Formanal		Baltimore 5. Social Security Nu		VA Cente		je (In yrs. la	est hirtho	lav)	Baltimo	If Under	24 Hrs.	8. Date of	Birth		9. Birt	nplace (Sta	ate or Foreign
Funeral Director		218-46-1. Usual Residence of	256	1 X M 2	□F	64	Yr	1.0	Months Days	Hours	Min.	(Month,	Day, Ye	^{ar)} 1946	Cou	intry)	Maryland
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with th	eral	2931 No		d Road					21234				100	Unite			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	**	Arm 1 X	Decedent ed Forces? Yes 2 — s, Give		S.	If Y	as Decedent of Hes, specify Cuba	an, Mexicai	n, Puerto	ecify Yes or N Rican, etc.)	lo-		ck, White	ican India , etc. hite	٦,
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12 should talth and Me 27 is mark r traumation		19a. Informant's Na	ame/Relationsh	ip (Type, Print,)				Address (Street	and Numb	er or Rura	al Route Num	ber, Ci	ty or Town,		Code)	
Page 1 and nent of Hea ant: If item ary or othe		20a. Method of Disp 1 🔯 Burial 2 4 🗌 Donation	☐ Cremation		I from State		emeterv.	crema	tion (Name of tory or other pla Memorial	Park		Date 6, 201		c. Location	-		:e
permit. Departr Importa any inju		21. Signature of Fu	neral Service L	censee	11			22.1	Name and Addre Evans Fun 8800 Har	ess of Facili	_{ty} hapel	& Crem	atia	n Servi	iœs-F	arkvil	le
Physician/		Immediate Cause (n failure. List o Final	complications nly one cause	that cause on each lin	d the deat	h. Do not	t enter	the mode of dyir	ng, such as	cardiac d	or respiratory	arrest,	Varylar Pase		Approx Interva	
Medical Examiner		disease or condition resulting in death)	on	f a. <u>C</u>	ue to (or as	a consequ	uence of)	<u> </u>	TIMEN	VCI		91	// 🗴	05			
pe sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying	b	ue to (or as	a consequ	uence of)):									
be executed sician and burial-transit	ical Exa	that initiated events c. The sulting in death Last Due to (or as a consequence of): Due to (or as a consequence of):															
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 horurs after death. To the Funeral Director Affer this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent			es, outcome			3 🗆 1	Ectopic pregnan	cv					ate of de	-	
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tal or Atterns after de al Directo		3 /☐ Suicide 4 ☐ Homicide	6 ∐ Could i determ		Place of In building, et			n, stree	et, factory, office 28f. Location (Street and Number City or Town, State)					ber or Ru	ral Route M	lumber,	
ne Hospi in 24 hou ne Funer pleted fill	Medical	(Check 2	Medical E	xaminer: On t	he basis of	examinatio	n and/or	investig	cured at the time pation, in my opin ath occurred at the	ion, death o	occurred a	t the time, da	ite and	place, and d	lue to the	cause(s) an	d manner stated.
To the vithing the complete of	-	29b. Signature and	title of certifier	M		£			29c. Licens	se number	17		290	d. Date sign	ed (Monti	n, Day, Yea	r)
4+1		30. Name and addr	ess of person	vho complete	d cause of	death (Item	1 23a) (Ty	/pe, Pri	hoch	D		D).	<u>ا۔</u> آ	D	1.1	171	
Sta	te	31. Date filed (Mont		THEIR	32. Regist	rar's Signa	39 ture	00	Loch	Nav	en	DIU	1,	Da	170.	11d	21218
Registr	ar	00 0	E 2011	1		1 4	Go. N.										

			For State Registrar	State of IVI	aryland / Dep Ce	ertificate of L			giene Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, La	,				2. Date of Dea	ath	Year	3. Time of Death
Jene .	Medic	al	Odessa Wood		n	1		Month 06	29 1	2011	9:07 AM
-	Examin	er	2900 Tallow Lan	•		Bowi	Location of Death			unty of Death	George's
	Funeral Director		5. Social Security Number 6. 8		e (In yrs. last birthday) 61 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 01/09/	h	_	place (State or Foreign
	and show Lat	٥	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Maryli 28a-f otifie	irect		George's	Bowi		<u>. </u>				1 🗌 Yes 2 🛭 No
	ith the 23a or st be n	ralD	10e. Street and Number 2900 Tallow Lane			10f. Zip Code 2071	5		10g. Citizer	of What Cour	•
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 1	Race - Americ Black, White, ecify: B1a	ean Indian, etc.
15-0	2 hours "natura edical E	Completed by	15. Decedent's (Specify only highest g	Education	(Give	edent's Usual Occup	during most of work	ing	16b. Kind	of Business Inc	dustry
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Maryland 21215-0036	d be filed v Aental Hyg Irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Charlie Fle				18. Mother's Nam	e (First, Middle, Wade		name) ack	
	nd 2 should ealth and N m 27 is ma	5	19a. Informant's Name/Relationship (ling Address (Street of 1900) Tallow		al Route Numbe	ID 207	15	
Baltimore,	Page 1 al ment of H tant; If iter jury or oth		20a. Method of Disposition 14 Burial 2 Cremation 3 4 Donation 5 Other (Spec		Glen Hav	en Mem. P	ark 07/0	-	Gle	tion - City or To n Burni	Le, MD
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licer	TO MO	1574	Singleton	Funeral	& Crema	tion		Burnie, MD es, PA
V V	h, i i n Medical Examiner	_	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	e. 1 C faul a consequence of):	ter the mode of dyin	_			DUA	Approximate Interval Between Onset and Death
760 760	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	Gederital state of the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c	a consequence of):						
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	☐ Ectopic pregnand	су		230	d. Date of deliv	ery Day Year
s, P.O.	requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause gi	ven in Part I.			_	he cause of death?
Division of Vital Records,	'sician; The law requ s certificate has beer lirector, page 2 shou	Somplete						24a. Was auto perfo		24b. Were auto prior to co death? 1 ☐ Yes	psy findings available ompletion of cause of
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of Vi	Physical this ceral direction	e: 1	1 Yes 2 No 27. Manner of Death	1 Inpat 28a. Date of inju		ent 3 L DOA 28c. Injur	4 ∐ Nursing Ho yat	ome 5 Resident			/)
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)ivis	al or Attendi s after death I Director: A d in by the fi	Certificate:	4 Homicide determine	28e. Place of Inj	iury - At home, farm, s cc. <i>(Specify)</i>	treet, factory, office		28f. Location (City or Tov		lumber or Rura	l Route Number,
_	To the Hospital or Attending Physician; The Is within 24 hours after death. To the Funeral Director. After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 Medical Exam	niner: On the basis of	f my knowledge, death examination and/or inve	estigation, in my opini	on, death occurred a	it the time, date	and place, ar	nd due to the ca	ause(s) and manner stated
ø	To the within 7 To the Comple		30. Name and address of person who Date it & W	Treut	erp	29c. Licens		72	29d. Date s	signed (Month,	Day, Year)
	1		30. Name and address of person who	completed cause of a	death (Item 23a) (Type	Print)	ey gro	en he i	14,00	D 20	5776
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 6 2011	32. Registr	ray's Signature	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) Month Physician 450 M 2011 Alexander Moite /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 | F 692-12-9394 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-C "natural", or items 23a or Funeral Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Evaminar 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willhoite Williamsburg, VA 23188 228 Beeston Fields, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation Williamsburg, VA 3 Removal from State Villiamsburg Memil Park 5 Other (Specify) 4 Donation 22. Name and Address of Facility Nelson Funeral Home 3785 Strawbarry Plains Rd. Williamsburg, VA 21. Signature of Funeral Service Lica see 3785 Strawberry Mounn 2mm 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death aloba Immediate Cause (Final Drain **Physician** disease or condition resulting in death))/Medical to (or as a consequence of) Examiner yr as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Box 68760, Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) by the 9 Unknown of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ Director: After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation Injury the Hospital or Attending 1 🗌 Yes 2 No Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a
To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 poleted cause of death (Item 23a) (Type, Print) Kobertson 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's 6 State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wade Jane Λ . July 201°1 6:43 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice of Columbia Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 11 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-34-9887 1 ☐ M 2 🛣 F Months Hours Min. 1939 Washington DC 71 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director Columbia |Maryland Howard 1 Tyes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral 7348 Rocky Creek Drive 21046 United States nit. Page 1 and 2 should be filed within 72 hours after death artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Prince George's College (1-4 or 5+) 5+ Elementary/Seconday (0-12) County Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Wade Η. Annie Jane McCue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Davis / 785 Cantiberry Dr., Salisbury, North Carolina 28146 Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 07/05/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Taylor 21. Signature of Funeral Service Licensee ALVSON K 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or compl ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ UPORS Medical resulting in death) Due to (or as a consequence of) ^{*}Examiner Sequentially list conditions, Examine Due to for as a consequence of: cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant : 5 Other (specify) Pregnant at time of death the i ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner Toth 29d. Date signed (Month, Day, Year) Codar Cano Columbia MD 21044 31. Date filed (Month, Day, Year, State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rederick Woltm	nan	Sta 1- For State Registrar	ate of Maryla	•	artment of		and	Mental I		2 0 Reg. No.	Standings	2135
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle	Fred		Werner	Wolt	ıan		2. Date of Dea			Time of Death
nedicai Exami	ner	FREDERICK 4a. Facility Name (if not institution	w give street and nu	mber)	WOLTMA		m orle	ocation of Dea	June 27,	2011 4c. County of		1618 hrs
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Funeral			6. Sex	7. Age (In yrs.		If Under	_	If Under 24H	_	rth(MM/DD/YYYY)	9. Birthpla Foreign	
Director		207-30-7249	1XM 2 F		L Yrs	Months .	Days	Hours M	". Jan 20	0, 1940	Country	_{y)} PA
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					104	d. Inside City Limits
È.,,	5	Maryland Baltim	ore Count	у	Balti	imore					1	Yes 2 X No
Maryle	Director	10e. Street and Number		1	 	10f. Zip Co				10g. Citizen of Wha		?
death with the Maryland or items 23a or 28a-f sho		242 Blenheim				<u> </u>		1212		USA		
eath w	Funeral	11. Marital Status 1 Never Married 2 Ma	rried Armed Fo		Unk 13. Wa	es, specify (of Hispa Cuban, N	anic Origin? (\$ Mexican, Puerl	Specify Yes or No to Rican, etc.)	o- 14. Race - White,		Indian, Black,
after d	by Fi	3 Widowed 4 X Divo	1 Yes rced If Yes, Give Yee or Dates:			Yes 2X	No .	specify:		Specify:	White	e
hours fram		15. Decedent's Education (Spec	ify only highest grad		16a. Deceden during m			n (Give kind of O NOT use re		16b. Kind of Bus	iness/Indus	stry
336 thin 72 than 'than'	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	Port	folio	Man	ager		Banki	ng/Fi	nancials
5-00 lled wi Hygien the M		17. Father's Name (First, Middle, I		TT- 1 .	.1		18			Maiden Surname)		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. taot: If item 27 is marked other than "natural", or items 23s or 28s-f abor other traumatic event, the Medical Examiner must be notified at poss	To Be	Frederick 19a. Informant's Name/Relationsh				Addross ((Street -			ine Werne		0.11
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Baltimo permit. Page Department o Important: injury or oth		21. Surfeture of uner Sanies Martin D. Laws	icensee Human		7 41	TCHEC	dress of	EDEFEL	D FUNERA	L HOME, Maryla	INC.	212
Physician		23a. Part I. Enter the disease, or o	omplications that ca	used the death	n. Do not enter th	ne mode of d	lying, su	ich as cardiac	or respiratory arr	est, shock, or hear	rt A	pproximate Interval
iMedical Examiner		failure. List only one cause of Immediate Cause (Final disease	n each line. a. As phyxia								В	Between Onset and Death
		or condition resulting in death)	Due to (or as a	consequence o	of):							
	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	of):							
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876 rtificati	M/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of preg rth		tal death	3	Ectopic pregr	ancy	23d. Date of d Month	lelivery Day	Year
Box 68760, in death certificate be early cartending physician of for use as the burial	Physician/M	1 Yes 2 No 9 Unkr		ant at time of de	eath 5 Oth	ner (Specify,)					
O. B it the d		Part II. Other significant condition			esulting in the u	nderlying ca	use give	en in Part I.	23e. Did to	obacco use contrib	ute to the	cause of death?
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Division • Hospital or Atteodit 124 hours after death. • Fluoral Director: A etely filled in by the fu										toute Number, City		
Hospital 4 hours a fuceral 1												
Division of Vital Records, P.O. Box 6876 To the Hospital or Atteodiog Physician: The law requires that the death certificate within 24 hours after death. To the Fuocral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	Medical		Iner: On the basis of and manner st	f examination a								use(s)
F > F 0	ž	29b. Signature and title of certifier					icense n			29d. Date signed		Day, Year)
		20 Name and office	h 1		00-1	°	C.M.	E.		June 28, 20	11	
-		 Name and address of person w Ana Rubio MD. Assis 	no completed cause stant Medical E	•	,	more Stre	eet, Ba	altimore, M	D 21223			
	ate	31. Date filed (Month Open Year)	32. Ru	trar's any et	Her							
Regist	LEL L	200 0 0 2011										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 21352 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month Year ALLEN 35 AM MUN 20 Medical 011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONICOMERY MASTINGTON ADVENTIST HOSPITAL TAKOMA PAR Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 XM 2 □ F Min. Months Hours Month, Day, Ye APRIL 18 1935 WEST VIRGINIA **Director** 577-46-1941 76 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4410 OGLETHORPE STREET UNIT 708 20781 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married Black, White, etc. <u>\$</u> Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12TH TRUCK DRIVER PRIVATE Be permit. Page 1 and 2 should be filed Department of Health and Mental H-Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20781 JANIS LORETTA ALLEN/WIFE 4410 OGLETHORPE STREET UNIT 708 HYATTSVILLE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) RIVERDALE CREMATORY :6/22/2011 RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease shock, or healt failure. U or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Physician/ Onset and Death disease or condition LACTIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Pregnant at time of death Day 4 Pregnant 9 Unknown 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Tunknown funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Yes 2 No 1 Yes 2 K No Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) မ 1 ☐ Yes 2 ☑ No ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deal To the Funeral Director: Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier WU DO 69051 JUNE 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo. BERNICE X1000 7600 CARROLL AVENUE, TAKUMA ATRK, MIREDU 31. Date filed (Month, Day, Year State JUN 2 2 2011 Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:40 pm Charles Ignatius Byrne Oi Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death stal Hospice at the COMICO 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) MD 1 M 2 D F Months Hours 1/15/1933 78 **Director** 212-30-4852 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a, State death with the Maryland 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be once. Funeral 11003 Grays Corner Rd. USA 21811 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married X Married Completed by XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Specify: White Year or Dates.Army 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Byrne Leota Grieb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Principe (daughter) 7703 Old Ocean City Rd. Whaleyville, MD 21872 harl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1st State Crematory Millsboro, DE 6/21/2011 21. Signatury of Funeral Service Lie 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RSOPAAGRAL MALICNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dualto (or as a consequence of). that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burla Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires I within 24 hours after death.
To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Tes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICIE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tosp, tal Rd. Salisbury MD 21801 DR. Ghulam Waris)eers

State Registrar 31. Date filed (Month, Day, Year)

VCDES

32. Registrar's Signature

11-04650 Ruby H. Benson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/ H. Bensor		State of Maryland / De 1-For State Registrar	partment of Certificate of		Mentai Hy		2011 a. No.	21354			
Physici lical Exami		Decedent's Name (First, Middle, Last)	···	-			Day Year	3. Time of Death 0620 hrs			
ncar Exami	mei	Ruby H. Benson 4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Lo	cation of Death	June 21, 20	4c. County of Dea				
		Atlantic General Hospital		Berlin		T	Worcester				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr 236 - 72 - 8222 1 M 2XF 59	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth	/1952 9. B				
ny		Usual Residence of Decedent 10a. State 10b. County 10c. C	city, Town or Location	on				10d. Inside City Limits			
Maryland 28a-f show any d at ouce.		DE Cussey									
arylan Sa-fs	Director	10e. Street and Number	agsboro	10f. Zip Code		109	g. Citizen of What Co	untry?			
the M	흅	145 Deer Run Road 19939 USA									
IIIOTE, MID. X 1 X 10-0000 Pages 1 and 2 should be filed within 72 hours after death with the Maryland vart of Healist and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 X No.	If Ye	s Decedent of Hispa es, specify Cuban, M	lexican, Puerto I			rican Indian, Black,			
2 hours after "natural", Examiner	À	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed		Yes 2 X No s		ork done	Specify: W 16b. Kind of Business	hite			
Ide filed within 72 hours after fled within 72 hours after flental Hygiene. anrked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life. De			Tob. Kind of Business	windusity			
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ould b d Meni marl	5	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a			per, City or Town, Star				
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permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Mediuny or other traumatic		1 Burial 2 K Cremation 3 Removal from State	crematory or oth		6/.	30/11	20c. Location - City of				
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hysician Marical		23a/Part I. Enter the disease, or complications that caused the de tailure. List only one cause on each line. Immediate Cause (Final disease a. Acetaminoph			ch as cardiac of	respiratory arres	st, snock, or heart	Approximate Interval Between Onset and Death			
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tal or Attending Physician: The law requires that as after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be det	Completed					24a. Was a		autopsy findings available completion of cause of			
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Physic r this al dire	2	1 Yes 2 No lospital 1 Inpatient 2					Residence 6 Oth	er:			
iding Ph. th. : After tl e funeral		1 Natural 5 Pending (Month, Day, Year)	28b. Time of Ir	1 Yes	2 X No						
Hospital or Attending Physician: 24 hours after death. Funcral Director: After this certif tely filled in by the funeral director,	Certification	2 Accident Investigation 1d 6-20-11		Upm		28f. Location (St	treet and Number or F	acetaminop Rural Route Number, City			
ospital or hours aft uneral Di ly filled in	i i	det and and	ate dwel	ling		or Town, Str 145 Dee		sboro, DE.			
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my know									
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and manner stated. 290-Signature and title of certifier	on and/or investigat	29c. License n		the time, date a	29d. Date signed (M				
	-	V (L l and		O.C.M.			June 22, 2011	and property			
	(30 Name and address of person who completed cause of death (i	tem 23a)								
		Laron Locke MD. Assistant Medical Examine	er 900 W. Ba		Baltimore, N	1D 21223					
S Regis	tate	WILLIES TO 100 TATALE TO 100 TA	nature A.	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2011 Physician/ June 6:00 A. 12, Betty Golden Breed Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death A. Facility Name (if not institution, give street and number)

Center

Citizens Care and Rehabilitation Frederick Frederick . Social Security Number 6. Sex 1 Year If Under 24 Hrs. Age (In vrs. last birthdav) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕃 F Months Days Hours 234-44-1786 80 **1**930 West Virginia Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21701 10209 Allview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bank teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jeannette Miller Revy Golden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10209 Allview Drive, Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print) Nathan Breed, Jr. - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Glade Cemetery 6-18-2011 Walkersville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 217Q2 same 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Scienosi Physician/ ATHERW disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12.months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accider 5 Pending work' 1 🗌 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Ave toll theDenica Mn 21701 KAZMI 814 31. Date filed (Mon State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUNE Physician/ JOSEPH ROGER BOND 2011 1:24P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth Funeral Days 1 🗆 XM 2 🗆 F MARY LAND JUNE. 1935Director 213-42-8088 28a-f shov 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Funeral Director PRINCE GEORGE'S CAPITOL HEIGHTS 1 Yes 2 No 10e Street and Number 10f. Zip Code 6 10g. Citizen of What Country? items 23a 419 BIRCHLEAF AVENUE 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: BLACK 1 ☐ Yes 2X No Specify: Completed 3 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha PRIVATE 9TH TRUCK DRIVER event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OVELL BOND CHRISTINE GREENFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 4049 BRUMMEL ROAD PASADENA MARYLAND 21122 PEGGY BOND/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2011 RIVERDALE, MARYLAND RIVERDALE CREMATORY 22. Name and Address of Facility Signature of Funeral S J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. of line. Approximate Interval Between Onset and Death e con line Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-tran Due to (or as a consequence of) nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as use yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) JUNE 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. CHEVERLY MD 20785 DR. MALIKA FAIR 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JUN 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #29d, 66/30/11, RM, Ken State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\boldsymbol{19}^{\text{Day}}$ Physician/ 201^{Year} JUNE 2:00 \mathbf{P}^{M} WILLIAM OTTO COXON JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER MANOR KENT CHESTERTOWN 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** APRIL 11,1927 MARYLAND Days Hours M 2 🗆 F Director 220-30-2610 84 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct MARYLAND KENT CHESTERTOWN 1 Xes 2 No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 210 WALDO DRIVE 21620 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: Race - American Indian, 11. Marital Status or other traumatic event, the Medical Examiner Black, White, etc. or 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **FARMER** AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ပ WILLIAM OTTO COXON, SR. MARY PAULINE WILLHEIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 FRANCES TAYLOR COXON/ WIFE 210 WALDO DRIVE CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESTER CEMETERY JUNE 24 2011 CHESTERTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kick V. ELLOWS HELFENBEIN AND NEWNAM FUNERAL HOME PA ے Heations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a, Part 1, Enter the disease, or com-Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? has autopsy performed 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica Be 26. Place of Deat (Check only one) examiner? Other: 2 N ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28h. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No within 24 hours after death To the Funeral Director: / completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the Octifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of celtific 29d. Date signed (Month, Day, Year) 2 BHGB Chestertan ms State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended#2perMD FCHD KS 6/20/11 Certificate of Death

Reg. No. Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death June 17, 2011. Time of Death Physician/ June. 2011 DAVID MILBY CROSS 6:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5787 Hurdle Hill Court Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Days Hours Sept. 25, 1 X M 2 D F ^(ear) 1941 Maryland 213-42-9088 **Director** 69 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland | Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5787 Hurdle Hill Court 21703 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black White, etc. 0 1 ☐ Never Married 2 🋣 Married þ 72 hours after 1 ☐ Yes 2 X No Specify: d Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced Completed White Year or Dates the Medical 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Federal Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Otha Cross Ida Faye Hendershot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5787 Hurdle Hill Court, Frederick, MD 21.703 Jean Cross / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 6/21/2011 Smithsburg, Maryland Signature of Funeral Service License RÖBERTndÉddre DATEEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
Chronic Immediate Cause (Final Physician/ Prostate Cancer disease or condition) Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical phys: attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 🗆 No 22 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Mannet of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending thin 24 hours after death.

the Funeral Director; After mpleted filled in by the fun work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nyrsa Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nyrsa Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32 Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manish Agrawal, MD

31. Date filed (Mont)

D0062234

6420 Rockledge Drive, Suite 4200, Bethesda, MD

June 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Day Physician/ 2206 hrs^M Melvin Cox June 18. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 X M 2 🗆 Hours 79 Director 243-42-9847 North Carolina July_ Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at **Funeral Director** 28a-f 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10g. Citizen of What Country? ō items 23a **United States** 6939 Georgia Avenue, N.W.; Apt. 615 20012 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 2 Yes 2 June 1952
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked others. by 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: **Black** Completed 3 X Widowed 4 Divorced Year or Dates. May 1954 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Taxi Cab Company 2 years Taxi Cab Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Moody Cox Bessie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Underwood Place, N.W.; Washington, D.C. 20012 James Weldon Cox (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State June 28,201 4 Donation 5 Other (Specify) Quantico National Cemetery Quantico, Virginia Signature of Funeral Service License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D..C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ AWTER MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DISENSE ARTERU DIROW VARY if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events at initiated events. Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 Yes 2 No 3 Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Pyes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Day, Year) JOORY JUNE 20, 2011 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CHERRY AVENUE, TAKOMA PARK, MARYLYND FUEGP. TERRY JODRIE IND

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26 per PHYS, G917, 7/672011 WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT HAYDEN CRAWFORD JR. 20 m JUNE 2°4 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ST. MARY'S HOSPICE HOUSE ST. MARY'S CALLAWAY Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1X XM 2 □ F Months Days Hours Min OCT . 5 1959 **Director** 51 VIRGINIA 579-86-8221 Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD ST. MARY'S **MECHANICSVILLE** 1 ☐ Yes 2X No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36690 HUMMINGBIRD COURT 20659 U. S. A. items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 🗌 Widowed 4 🔲 Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) COMMERCIAL TRUCK DRIVER R&R FABRICATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT HAYDEN CRAWFORD SR. JULIA JOYCE STYLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA J. CRAWFORD 36690 HUMMINGBIRD CT., MECHANICSVILLE, MD20659 WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JUNEate 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State IMMANUEL CH.CEM. 4 Donation 5 Other (Specify) 29,2011 BADEN, MARYLAND Signature of Funeral Service Licens 21 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. >M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ amyotro disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Director for the discrepance of burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available has autopsy perform prior to completion of cause of death? this certificate 1 Yes 2 No Yes 2 or Attending Physician: apleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' nospice House 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: After 28d. Describe how injury occurred Natural injury 5 Pending Investigation 6 Could not be Accident **Director:** 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and tite of certifie 29d. Date signed (Month, Day, Year) DO055682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ST Leonardtown 23130 Moakley State Registrar

V

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death HUL aclotte T aru Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 M 2 D F Hours Director 174-16-3870 20,1919 PENNSYLVANTA Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 XYes 2 No MD ALEXANDRIA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4022 TANEY AVENUE 22304 U.S. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1¾ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Year or Dates. W. W. II the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) BUDGET ANALYST DEPT. OF THE ARMY Be Department of Health and Mental H, Important If Item 27 is marked oth any Injury or other traumatic once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY CAFEO EVELINE GATO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY CAFEO / SPOUSE TANEY AVENUE ALEXANDRIA, VIRGINIA22304 4022 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT.CEM UNK ARLINGTON, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. end Bas M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to or as a consequence of if any leading to immedicause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: NA 23b. Was decedent pregnant NA 11 Se 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death Po Month Day Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 24 hours after death. Funeral Director: After this funeral 27. Mannep of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred alc Natural 5 Pending 2 Accident
3 Suicide
4 Homicide A 2 🗌 No Investigation the NI 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State) or Rural Route Number, filled in by determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 26 2011 WILLIAM FRANCIS COLLINS 10:09P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MD HOSPITAL CENTER PRINCE GEORGE'S CLINTON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 XM 2 D F Months 220-34-8468 MARYLAND Yrs Director 1938 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director MD CHARLES 1 Yes 2XXNo BEL ALTON 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 9265 CRAIN HIGHWAY 20611 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or. Completed by 1 Never Married 2 X Mamied 1 Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CARPENTER CONSTRUCTION 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FRANCIS COLLINS AGNES ROSALIE FORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA N. COLLINS/SPOUSE 9265 CRAIN HIGHWAY BEL ALTON, MD 20611 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If its any injury or ot once. XXBurial 2 Cremation 3 Removal from State SACRED HEART CEM. JUL. 1, 2011 4 ☐ Donation 5 ☐ Other (Specify) LA PLATA, MD 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licens 5635 WASHINGTON AVE., LA PLATA, MD M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury Due to or as a consulence of physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year q | Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE Records, RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 2 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number D52900 ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 205 Glenn Da Homozolis

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Della-16:39 PM June 22 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bayuen Medral Cent Johns Hopkins Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days Min Jan. 9,1927 219-20-1637 Mary Land 84 Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Washington County 1 🗆 Yes 2 🛣 No Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11927 Iroquois AVe. 21783 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. :ant: If item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Activities Director Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Eaton Adams Nellie Mae Morningstar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8403 High Ridge Rd. Ellicott City, MD 21043 Brenda Hurbanis-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 6-27-2011 Greenlawn Mem Park Williamsport, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death/Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final iterval Between Onset and Death Septic Shock Physician/ day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner week neumont Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the Inneral director, page 2 should be detached for use as the burial-transified in by the Inneral director, page 2 should be detached for use as the burial-transif Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 **V**No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury work? 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number RES-000 June 22,204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ryan Childers 4940 Eastern MIP Baltimore MD 21224 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Month Physician/ 12:09 23 Nancy June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Broadmore Assisted Living g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, (Month, Day, ^{Year)}1940 **Funeral** Maryland 1 🗆 M 2 🔯 F Dec. 216-38-2294 Director Usual Residence of Deceden 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 K No Hagerstown Washington Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code the and 2 should be filed within 72 hours after death with : Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a Funeral U.S.A. 21740 1175 Professional Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. \$ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Customer Service Rep. 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hilda Naomi Sherley Paul Webster Wade, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 807 View Street, Hagerstown, Maryland 21740 item 27 Richard L. Derr/son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot once. Page 1 cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Boonsboro, Maryland 06/27/11 4 Donation 5 Other (Specify) Boonsboro Cemetery Bast-Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Rmentia Medical resulting in death) Due to (or as a consequence of) Examiner Tract Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Year Day in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 Ko 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) To Be 25. Was case referred to medica examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27 Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State

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Registrar

Registrar's Signatu

13424 Pennsylvania Are Hayer town MO 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 4:30 A M 14, FRANK LEROY DUXBURY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT CHESTERTOWN 21237 MAINE AVENUE 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1**X** M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Hours 1270171913 NEBRASKA 97 202-22-3670 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at 10a. State death with the Maryland Director 1 🗌 Yes 2 🗶 No MD **KENT** CHESTERTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **2**3a UNITED STATES 21620 21237 MAINE AVENUE items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 12 should be filed within 72 hours after de the and Mental Hygiene. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1934–45 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRANSPORTATION BUS DRIVER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ JOHN C. DUXBURY LUCY A. BLANDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 113 FRIENDSHIP ROAD DREXEL HILL, PA 19026 JOHN DUXBURY / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/16/2011 ROCK HALL, MARYLAND JOHN'S CEMETERY 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complete ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Onset Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner countrielly list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Arenia of chronic 1 Yes 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27, Manner of Death 28h Time of Certificate: Natural 2 Accide 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified of death (Item 23a) (Type, Print) 30. Name and address of

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Jume 16, 2011 Dixon 9:00A Josephine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Northampton Manor Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 83 Months Hours Min. Allenth 253, 1927 Pennsylvania Director 163-22-5010 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified . Vest Virgi<u>ni</u> Salem Harrison 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Route 5 Box 1022 26426 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Investment Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Crothers Samue 1 Mary Ellen Gary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6802 Wythe Court Frederick, MD 21703 Susan C. Higgins/Daughter item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State Floral Hill Mem Gard. 6/20/2011 Quiet Dell, WVa 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. In the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any Leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 🗷 No 9 ☐ Unknown the 9 Unknown Division of Vital Records, P.O. ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No certificate ! 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this upleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural injury 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year) D0061410

Registrar

State

31. Date filed (Month, Day, Year)

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TOLL HOUSE, FREDERICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 June 16, 12:00 nown Rosemarie U. Evans Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Kline Hospice House Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day You Sept 20, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1940 Months Days Hours 70 315-60-3009 Germany Director Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d, Inside City Limits rector Frederick Maryland Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral USA 1616 Rock Creek Drive 21702 filed within 72 hours after death n "natural", or iter fedical Examiner r 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify. Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) 5+ College (1-4 or 5+) Accounting Manager Insurance permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johannes Seiler Carola Kittler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 10087 Vista Court, Myersville, Maryland 21773 Joanne Smith - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 06/20/2011 Frederick, Maryland Signature of Funeral Service Lipensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ PANCREATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? 2 No 1 🗌 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? HOSPICE HOUSE Other: 4 \(\sum_{\text{Nursing Home}}\) Hesidence 6 \(\mathbb{L}'\)Other 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at s after death. 28b. Time of 28d. Describe how injury occurred 5 Pending work? 1 \square Yes 2 🗌 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of sertifier lu m DZ1936

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VOHNENDR, FREDERICK, MD ZIJOZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Year Month Alice F. Fasanella 14, June 2:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5106 Valley Pine Court Frederick Frederick Funeral Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign oct. 23, 1 □ M 2 □XF Year) 1921 Missouri Months Hours Director 489-24-4316 89 Usual Residence of Decedent show 10a. State 10b. County death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5106 Valley Pine Court 21703 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? à Black, White, etc. should be filed within 72 hours after or and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Decorator Interior Design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luther Patrick Vennie Mayhugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Arden McElroy / Daughter 5106 Valley Pine Court, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/17/2011 Stauffer Crematory Frederick, Maryland Signature of Funeral Service Licen Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Interval Between Immediate Cause (Final Physician/ Due to (or as a consequence of): hear disease or condition cry resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate occur. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of) burial Physician/Medical that the death certificate be P.O. Box 68760 phys the k iding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Division of Vital Records, atrioventricular bock Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 ☐ Yes 2 No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 유 1 Tyes Nursing Home Kesidence 6 Dother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. Accident 1 Yes 2 No Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 7 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) (a) 1(a) 2011 NO 0056890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 02265 NO 91316 ardlara no 010

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State Registrar Russell Alexander MD.

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32. Red strar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Baker GIBNEY 340M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 21,1924 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. 220-16-1256 86 Maryland **Director** Yrs. Usual Residence of Decedent show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10b. County with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 937 W. Washington Street 21740 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 K Married ş Baltimore, Maryland 21215-0036 Yes 2 😿 No If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 12 College (1-4 or 5+) salvage/machinist truck mfg. Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked othen any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Carl Gibney Edith Mary Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas S. Gibney - son 4803 Cowmans Ct. N., Mount Airy, Md. 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/28/11 Hagerstown, Maryland Cedar Lawn Mem. Park 21. Signature of Funeral Service Lic. 23. Name and Address of Facility MINNICH FUNERAL HOME Merstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ accenoma disease or condition resulting in death) Medical lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oi). Examin Hospital or Attending Physician: The law requires that the death certificate be executed -trar Due to (or as a consequence of): resulting in death) Last nding physician use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ğ Day Year Pregnant at time of death the r Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 🗌 No 1 Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 hpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 29b. Signature and title of certifie 6-23-201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHIL NE HAGERSTOWN MD21742 BOUL WATTERD 12822 gistrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Doris Delores Givans June 1518 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 18 Saddler Avenue Ceci1 E1kton Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Min OCT 19. 1929 Director 81 Illinois 331-24-4718 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 Saddler Avenue 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Production Pepsi Cola is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Issac Allen McDaniel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke Evelyn Mary Fitzgerald any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Lawton/Daughter 18 Saddler Avenue, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Boulden Chapel Cemetery, crematory or othe Cemetery 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2011 Elkton, MD 21. Signat e of Funeral Service Licensee Micks Home for Funerals, 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Mauronia disease or condition Medical resulting in death) Examiner 090 Sequentially list conditions cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Day Pregnant at time of death signed by the a d be detached f Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Solvi 1 Yes 2 No 3 Probably W Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform No. 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referre Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ဂ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Dealt Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes Investigation Could not be after death Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in triy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) In ceil Bon My DO 4823

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHEILA PATRICIA HOLDEN 19 2011 6:05 P M JUNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CORDOVA TALBOT 12810 PEACH LANE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1<u>941</u> 1 D M 2 X F Days Months Hours Min (Month, Day,) **Director** 214-74-4776 70 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No TALBOT CORDOVA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21625 USA 12810 PEACH LANE 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hours bepartment of health and Mental Hygelne. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH KENNARD BUCKEL MARJORIE MARIE GARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12810 PEACH LANE, CORDOVA, MD 21625 JOHN EDWIN HOLDEN, SR./HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION JUNE 21 4 ☐ Donation 5 ☐ Other (Specify) 2011 <u>STEVENSVILLE, MD</u> 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 D Yes 2 X No Month 4 ☐ Pregnant at time of death g ☐ Unknown signed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 the Hospital or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d, Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and 29d. Date signed (Month. ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE SADIE MATILDA STOWMAN HASTINGS 2011 9:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN **KENT** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day Year
3-21-1924 Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🔀 Director 213-22-4909 87 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 CLIPPER WAY UNITED STATES 21620 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. d other than ", Elementary/Seconday (0-12) College (1-4 or 5+) the 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked oth njury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE W. STOWMAN SADIE M. BECK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY HASTINGS/SON 11020 PERKINS HILL RD. CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CHESTER CEMETERY 6-23-2011 CHESTERTOWN, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. e 130 SPEÉR RD, CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death G Wortu Immediate Cause (Final Invasive Transitional Careinome Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by : ASOVD: DUTYPOIL: 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 Yes 2 No Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Lirector After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours

To the Funeral I 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 6/20/2011 Doo 50996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mostartown MD 21620 Deil Staddard ICO Brown
egister's Signature MD 31. Date filed (Month, Day State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2011 SCHILDWACHTER NAOMI HERRON 19 Medical JUNE PM 4:30 **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🏝 F Months Days Hours 05/04/1923 Director 057-18-7835 88 NY Usual Residence of Decedent 28a-f show 10a, State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Frederick Frederick ō 10e Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 841 Dunbrooke Ct 21701 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 Yes Maryland 21215-0036 1 ☐ Yes 2 M No Specify: 3 Nidowed 4 □ Divorced Completed Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene.

7 is marked other than traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Reading Specialist Education Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant. If item 27 is marked viury or other traumatic ew ည Daniel A. Schildwachter Freida L. Maurer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Ruth Horak /daughter 805 Dunbrooke Ct., Frederick, MD 21701 Baltimore, 20a. Method of Disposition
1
Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Stauffer Crematory 6/25/2011 Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD Part 1. Enter the disease, or complications that caused shock, or healt failure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition decompensated 1 Medical resulting in death) Examiner aprila Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day the 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

After this funeral reral Director: A 24 hours after death. Funeral Director: A npleted f within 2 To the I

27. Manner of Death

1 Natural

29a Certifier

(Check

Accident

Suicide

Homicide

29b. Signature and title of certi

31. Date filed (Month Day, Year)

5 Pending

len

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1690

6 Could not be

Certificate:

Medical

10

Registrar

Memorial

egistrar's Signature

mun.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

M

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at

work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

2 🗌 No

D0070401

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amended#17perFH FCHD KS 6/23/11 Certificate of Death

Registrar

State of Maryland / Department of Health and Mental Hygiene
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day John Gilbert Hamlin 2011 5:25a June 16 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Year Months Min. 1 X M 2 □ F Days Hours Director 001-14-3258 89 Oct. 5, 1921 New Hampshire Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If them 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Its Medical Exerciting and usy or other traumatic event, Its Medical Exerciting. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1A Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1804 Granby Way Funeral 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🔼 No ģ Specify: Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray Gilbert Hamlin Roy Gilbert Hamlin Wava Richardson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Bettye Hamlin/ Wife 1804 Granby Way, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.6/18/2011 Frederick, Maryland 21. Signature of Ineral Service licensee Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that outset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5tuge disease or condition resulting in death) orny /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day signed by the a d be detached for 4 Pregnant at time of death 5 Other (specify) o. I Yes 2 No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2. No 2 🗆 No 1 ☐ Yes Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

8+1

Molecular Drive, Rockville, MD Suite 206

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110

Registrar's Signature

Julia Kariya M.D.

JUN 20 201

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Eugene Ross Holland, Jr. 2011 June 8, 12:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death R. Adams Cowley Shock Trauma Center Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🕅 M 2 🗆 F 214-52-8135 Hours May 24, Year)949 Virginia Director 62 Yrs Usual Residence of Decedent 10a. State the Marviand 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland Frederick 1 X Yes 2 No Frederick 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 223 East 6th Street 21701 United States ural", or items 2 I Examiner mus within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 ₩ Widowed 4 □ Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Energy Company event, 1 Be and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) (unk.)17. Father's Name (First, Middle, Last) of Health and Mental H if item 27 is marked ot r other traumatic ever ပ Eugene Ross Holland, Sr. Delores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Dawn Solomon / Daughter 7703 Bridal Path Cir., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 K Cremation cemetery, crematory or other place) June 2011 Resthaven Crematory 4 Donation 5 D Other (Specify Frederick, Maryland ral Service 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, P.A. MD 21701 23a. Part 1. Enter the disease, or co shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Injuries Medical Due to (or as a consequence of) Examiner PR VED BY Motor Vehicle Accident Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Myelo Proliferative Syndrome, Anemia, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of Thrombocytopenia, Splenomegaly has autopsy perform death? this certificate 2 X No 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ဂ္ဂ 1 🙀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 🕱 No 6/8/2011 Motor Vehicle Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Street East & South Street Frederick, MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, doesn construction d at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 0 Philip breeno 31. Date file (Month, Day, Year) Jarke State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Year **Physician** ELSIE BAILEY HUNT June 13 7:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5821 Queens Chapel Rd. #131 Hyattsville Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 6/17/20 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Days Year) 579-24-4029 Wash., Director DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5821 Queens Chapel RD 20782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk DC Govt. permit. Pages 1 and 2 should be filed beartment of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bailey Amanda Sneed မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Evelyn Washington/ Dtr. 1316 Emerald St. NE Washington, DC 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Harmony Menorial Cem. 6/20/11 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pridgen Funeral Service 21. Signature of Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 2 No 1[] Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☐ Nursing Home 【☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and marner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

CR 5

31. Date filed (Month, Day, Year)

JUN 2 2 2011

30. Name and address of person who co

32. Registrar's Signature

State

Registrar

eted cause of death (Item 23a) (Type, Print) 9200 Basil Court Suite 200 Largo, MD

20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JYYYE 17 20 Year 10:40 A M Gloria E. Howard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hvattsville Thomas More Nursing Home 5. Social Security Numbe 579-34-2002 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours JW17 21 1929 DC Director 81 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No N/A Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20019 13 Anacostia Ave, Northeast death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ۵ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥ No Specify: If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", **Black** 3 X Widowed 4 ☐ Divorced Specify: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adolphos Morgan Clara Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Teresa Howard/ Daughter 3225 Orient Fishtail Road, Laurel, MD 20727 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spent) Resurrection CemeteryJune 22,2011 Clinton, Maryland ure of Funeral Service Lic 22. Name and Address of Facility Pope Funeral Home, P.A. any 5538 Marlboro Pike, Forestville, MD 20747 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ hronic Obstructive Line DISACTER disease or condition 124.50 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral investor page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Respiratory failure Distriction Steepap we 1 Yes 2 No 3 Probably 4 Unknown Completed Ventilator idependence Concestive Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. FEITIVE Sewere Ohesity Hupertension 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Do 1852 JULLE 17 2011

State Registrar 4213 Quearshing Rd Hightsville MD 20781

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

one

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1) FV

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Management	aryland / Depa	artment of H			giene Reg. No.2	11 21379				
			Decedent's Name (First, Middle, Last)		timodito oi z		2. Date of Dea	ath	3. Time of Death				
	Physicia Medic		Martha Herchelroath				Jume 28	, 2011	Year 4:10 A M				
	Examin	er	4a. Facility Name (if not institution, give street and number) 8308 Jordan Valley Way			Location of Death rederick		4c. Coun	ty of Death Frederick				
1	Funeral		, ,	e (În yrs. last birthday)		If Under 24 Hrs.	8. Date of Birt	h	Birthplace (State or Foreign				
	Director		226-66-4174 1 □ M 2 🛣 F	60 Yrs.	Months Days	Hours Min.	(Month, Day April 5,	Year) 1951	Virginia				
	od at	ŗ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d, Inside City Limits				
	larylar 3a-f st iffed a	Director	Maryland Frederick			rederick			1 ☐ Yes 2 🛣 No				
	the M	۱Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of	f What Country?				
	h with	Funeral	8308 Jordan Valley Way			21702	United S	States of America					
	r deat or iten iiner r	y Fu	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 🗷 Married 1 □ Yes 2 🗷		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - American Indian, ack, White, etc.				
036	s afte ral", c Exam	ed by	3 Widowed 4 Divorced Year or Dates.	NO .	1 ☐ Yes 2 🗷 No	Specify:		Specif	fy: White				
2-0	2 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa kind of work done de		ina	16b. Kind of	Business Industry				
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/lan	d be fi	오	George Mather Wagner, Sr.			Eliza	beth Davi	is					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) George Wagner / Brother		ng Address (Street a. Sandy Valle				State, Zip Code) ginia 23111				
ore,	of Head of Head fitem		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place	a)	Date	20c. Location	ı - City or Town, State				
ij	Page ment tant: It		1 ☐ Burial 2 【本Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		g Crematory	June :	29, 2011	Smith	sburg, Maryland				
Balt	permit Depart Import any inj once.		21. Signature of Funeral anny by Licensee	M01433	Name and Address Keeney & Bas LO6 East Chu	s of Facility S ford P.A. Irch Street	Funeral H	lome .ck, Mary	land 21701				
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Zu.	Physician/	Immediate Cause (Final disease or condition Breast Cancer											
	Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. Due to (or as a consequence of):										
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687	eath certificate attending phi I for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. D	Date of delivery				
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ec.	he law te has l	Completed			autop perfo	opsy prior to completion of cause of death?							
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n of	I or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	Certificate:	27. Manner of Death 1 ★ Natural 5 □ Pending 28a. Date of inju	ry 28b. Time of injury	work		28d. Describe h	ow injury occu	rred				
Sio	Attendent deat cotor:	ıţiji		ury - At home, farm, str		163 2 🗆 140	28f. Location (Street and Number or Rural Route Number,						
Division of Vital Records,	tal or rs afte al Dire		building, etc	c. (Specify)			City or Tow	n, State)					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner; to the	xamination and/or inves	tigation, in my opinio	n, death occurred a	t the time, date a	nd place, and d	lue to the cause(s) and manner stated.				
_	To the within 7 To the comple	-	29b. Signature and tipl of cartifley	number			ed (Month, Day, Year)						
			P ////////	Mil	D5317	7		June 2	9, 2011				
71			30. Name and address of person who completed cause of d John Malmart, M.D. 9707 Med	eath (Item 23a) (Type, F ical Center D		300 Past-	villa Ma	rul and 2	0850				
	Stat	te	31 Date filed Month Pay, Year 2 32 Registry	parter 1	rive, ource	. Jov, NOCK	ville, fid	Ly LOUBL Z	V-0.50				
	Registra		JUL 0 6 2011 Lewer P. 18										

Registrar

DHMH 17 Rev 7/2009

State

JORGE ABREGO, MD

31. Date filed (Month, Day, Year,

Registrar's Signat

598 CYNWOOD DRIVE #104, EASTON, MD

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Joel Elliott Jackson 2011 :00 Medical Tune 2 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2047 Hopewell Road Port Deposit Cecil 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Date or L... Month, Day 11 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 X M 2 🗆 F 218-72-2127 Director 51 **.**1959 Maryland Usual Residence of Decedent or 28a-f shov iral", or items 23a or 28a-f shor Examiner must be notified at death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil 1 ☐ Yes 2 🂢 No Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2047 Hopewell Road 21904 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic anameter. à 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elkton Gas Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Elkton, Maryland Meter Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Howard Jackson, Sr. Mary Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Jackson (wife) 2047 Hopewell Road, Port Deposit, Maryland 21904 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place R.A.Ferris & Co., Inc. 06/17/11 Pennsylvánia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service ^{22. Name and Address of Facility} Lee A. Patterson & Son Funeral Home, P Perrvville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown has been signed 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha lirector, page 2 1 Yes 2 No 1 ☐ Yes 2 🔯 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 😾 Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier press of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 2 2

		1- For State Registrar		Re	Sam 8 % 67 60								
	Physician/ 1. Decedent's Name (First, Middle,Last) dical Examiner Rhett Edward Kuritz								2. Date of Death Month Day Year June 21, 2011			3. Time of Death 0925 hrs	
		4a. Facility Name (if not institution, give 17837 Justice Court	41	o. City, Town, or Hagerstown		f Death	4c. County of Death Washington						
Funeral Director		5. Social Security Number 6. Se 315-94-2634 1X		th(MM/DD/YY 26,1984		hplace (State or Foreign Tana							
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If titem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trawmatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washington 10e. Street and Number 17837 Justice Con 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify or Elementary/Secondery (0-12) 12 17. Father's Name (First, Middle, Last) Wayne Kuritz 19a. Informant's Name/Relationship (Tyulie Kuritz-wife) 20a. Method of Disposition 1 Burial 2 Acremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	yes 2 No. Yes 2 No. S Usual Occupa st of working life 1 ed Address (Stre Justic ion (Name of ce er place) C Cremat me and Address	n, Mexican, specify: ation (Give k e. DO NOT u 18.Mother's Sue et and Numt e Cou:	1 Yes 2 X 1 10g. Citizen of What Country? U.A.A. 11d. Race - American Indien, Black, White, etc. Specify: White (Give kind of work done of Not use retired) Wother's Name (First, Middle, Maiden Surname) UE Hawk Carter 10d Number or Rural Route Number, City or Town, State, Zip Code) Court Hagerstown, MD 21740				ite ndustry Zip Code) 40 Town, State 3, MD				
Physician /Medical Examiner												Approximate Interval Between Onset and Death	
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760, cate be executed physician and he burial - transit		UNPENDED AMENDED											
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify) 9 Unknown									•	lay Year	
P.O. E res that the esigned by the be detached	Ď	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.							d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown			
7 6 27	Completed	24								Vas an utopsy 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 ✓ No 1 Yes 2 No			
an: T	26. Place of Death (Check only one)												
Vit;	0	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient	2 ER/Ou	utpatient	3 DOA	Other ₄	Nursing H	Home 5	Residence 6	6 🗸 Other	: Scene	
Division of Vital Rectal or Attending Physician: The Is after death. al Director: After this certificate Itel in by the funeral director, page	ation: T	27 Marroy of Dooth 200 Date of John 1994 Time of											
Divisital or Att ours after de neral Direct filled in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single Family Home								Street and Nu tate) Court , Hag		ral Route Number, City MD	
Fo the Hosy within 24 hc Fo the Fun- completely t	Natural 2 Accident 3 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined 5 Specify Single Family Home 1 Table District Day Over Head 2 Accident 3 Suicide 4 Homicide 5 Specify Single Family Home 2 Set. Location (Street and Number of or Town, State) 17837 Justice Court , Hagerston or Town, S												
											nth, Day, Year)		
			nt Medical Examin	er 900 V	V. Baltir	more Street	, Baltimoi	re, MD	21223				
St Regist	trar 31. Date filed (Month, Day Year) 2011 32. Refistrar's Signature & January B.												

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar

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		For State Registrar	State of Ma	-	Department of I Ce <i>rtificate of</i> I			giene Reg. No	21383	
Physicia	an	Decedent's Name (First, Middle, Last)	. 10	1	Leffy		2. Date of Dea Month	Day Ye	1 M	
/Medic Examin	al	4a. Facility Name (If not institution, give stre	eet and number)	· · ·		r Location of Death	June	4c. County of D		
		The Johns Hopkins Hos 5. Social Security Number 6. Sex		(In yrs. last birti	Baltimore	City If Under 24 Hrs.	8. Date of Birth	1 19	Birthplace (State or Foreign	
Funeral Director		173-34-5345	1 2 □ F	C 7	Yrs. Months Days	Hours Min.	Dec. 9,	1943 Pe	ennsylvania	
/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
ne Mary 18a-f sh tiffed a	ector	WV Berkeley		Marti	nsburg				1 X Yes 2 □ No	
3a or 2	Funeral Director	10e. Street and Number 635 Dry Run Rd.			10f. Zip-Code 25401			10g. Citizen of What U.S.A.	Country?	
er death	uner	11. Marital Status	. Was Decedent Ev		13. Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc.	
al", or	by	1 ☐ Never Married 2 ☐ Married 3 🔏 Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 XNo	Specify:		Specify:	White	
"natur	leted	15. Decedent's Educa (Specify only highest grade o	ompleted)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	king	16b. Kind of Busine	ess/Industry	
d withingiene.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	·) Na	val Intelli	gence Of		U.S. Mili	tary	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (17. Father's Name (First, Middle, Last) James Francis Kell	.y				_{ne (First, Middle,} Laughlin	Maiden Surname) Kelly		
d 2 sho th and the stand the stand the stand the stands trauma		19a. Informant's Name/Relationship (Type Brian F. Kelly-son	Print)		Mailing Address (Stree 8832 Exeter					
es 1 an of Heal fitem 2 rother		20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Rer	noval from State	20b. Place of	Disposition (Name of y, crematory or other pla	t	Date	20c. Location - City		
it. Pag rtment rtant: Il njury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	noval nom otate	Arling	gton Nat. C		JNK	Arlington		
Depa Impo any ii		Dienes AS	Fine		1331 East		_	. riery r Hagerstow	uneral Home m, MD 21742	
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused to cause on each line	he death. Do n	ot enter the mode of dy	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sept. Due to (or as a	consequence of	of):		_			
Examiner	ē	Sequentially list conditions, if any, leading to immediate	emp Due to (or as a	Consequence of	of).					
xecuted and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
0 1	=	resulting in death) Last	Due to (or as a	consequence of	of):					
rificate be ex ng physician a s as the buria	Physician/Medical	IF FEMALE:								
attendir for use	ician/	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	☐ Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of Month	delivery Day Year	
tt the di by the	Phys	9 Unknown	9 Unknown							
uires tha	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
aw requ s been 2 shou	Completed						24a. Was a	sy prio	e autopsy findings available r to completion of cause of	
t: The l		25. Was case referred to medical	_			26 Place of Door	perfor Yes	2 No 1		
ysiciar s certifi directo	To Be	evaminer?	spital: 1 Inpatien	t 2 🗆 ER/Out	patient 3 DOA Oth	ner:	th (Check only or ome 5 ☐ Resid	ence 6 🗆 Other (S	Specify)	
ling Ph	ion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day		ime of 28c. Injury Wo	ry at rk?]Yes 2 □ No	28d. Describe h	ow injury occurred		
or Atteno	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.		m, street, factory, office		28f. Location (S City or Town		or Rural Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical Ce			examination and	, death occurred at the t d/or investigation, in my					
To the within 2 To the I	29d. Date signed (M	onth, Day, Year)								
K		Deat Make	MD		Pos	3-0000		June 2	1 2011	
arl		30. Name and address of person who com	pleted cause of de	ath (Item 23a)	(Type, Print)	600	North Wo		more, MD, 21287	
Sta	te	31. Date filed (Mostle Or)	32 Registrar	s Signature	alex .			,	, , , , , , , , , , , , , , , , , , , ,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 201 Lottie S. Krok Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2X F Months Days Hours Min. 0970571920 Pennsylvania Director 187-05-3048 90 Usual Residence of Decedent Alto be more and Martal Hygiene.

Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other marked at the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland | Prince Georges Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20706 9424 Buena Vista Ave. U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 \square Never Married 2 \square Married 21215-0036 1 Yes 2 XNo Specify: 3X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be Page 1 and 2 should be filed ment of Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Stanley Biedrzycki Sofie Slaveck 19a. Informant's Name/Relationship (Type, Print) item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanore Moore (Daughter) 9424 Buena Vista Ave. Seabrook, MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If it
any injury or or
once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 06/25/2011 Clinton, Maryland Signature Fineral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home unine 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury that initiated events been signed by the attending physician and should be detached for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) g Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? É 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, æ 26. Place of Death (Check only one) 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State 24 hours Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) ROAD, LANHAM Good Luck Abjod 31. Date filed (Month. State JUN 2 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Month June James C. Mason 0200 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number 8. Date of Birth March 1 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours n 12,1961 Maryland Director 212-80-4701 50 Usual Residence of Decedent 28a-f show 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🗭 No Maryland Montgomery Damascus 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10429 Sweepstakes Road 20872 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married ģ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Landscaping Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Tommy Nelson Mason Roxie Rutherford Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Mason, Wife 10429 Sweepstakes Road, Damascus, MD 20872 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ECremation 3 Removal from State cemetery crematory or other place)
Metropolitan
Crematorium Inc. 4 Donation 5 Other (Specify) June 17,2011 Alexandria, Virginia Signature of Furjeral Service Lice 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate shock or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated successions) Due to (or as a consequence of) Exam The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perforn death? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068080 June 14, 2011 ess of person who completed cause of death (Item 23a) (Type, Print) Sireesha Jallii, 9901 Medical Center Drive, Rockville, MD 20850 MD31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

of Vital

Division

Chargesa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Moxle 12:42AM 2011 aria ampbel June 16 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State br Foreign Country) Irvington Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 👿 F Days March 5 Director 222-48-6099 Delaware Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No New Castle Newark DE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō Canzonet 19702 items 23a United States filed within 72 hours after death v Hygiene. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'naturaj", or 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manana injury or other traumatic event, the Manana injury or other traumatic event. Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desi E. Moxle Executor Canzonet 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State Mayerdale Crematory June 18,2011 Newark 22. Name and Address of Facility Spicer - Mulli Kin Du Pont PKY New Castle DE 1000 N. t caused the death. Do not enter the mode of dying, such as cardiac or respirtory arrest, on each line. rart1. Enter the disease, or complications shock, or heart failure. List only one caus Approximate Interval Between Onset and Death Immediate Cause (Final Physician Thronic graft disease or condition resulting in death) hast disease versus Medical Due to (or as a consequence of): Examiner Stem cell transplant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Primary thrombocythemic Due to (or as a consequence of): and physician a the burial-t Box 68760. Physician/Medical signed by the attending place as be detached for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by maras mu 2 No 3 Probably 4 Unknown 1 🗌 Yes End stage 1mmobi 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed es 2 No Chronic respiratory
25. Was case referred to medial examiner?

1 Yes 2 No Hospital: After this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 28462 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Boston

Irvington

22 South Athol Baltimore, Maryland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CATHY J NIGH 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11 W. Baltimore St. Apt 914 Hagerstown Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 55 16.1956 Maryland 220-76-1493 **Director** April Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 11 W. Baltimore St Apt 914 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 N Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) Interior Design Co. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard LaDue Nigh 19a. Informant's Name/Relationship (Type, Print) Dustin Kochera-son 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date cemetery, crematory or other plac Cumberland Valley Crematory 6-24-2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, second ior tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Altrerosde Physician/ disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a sunsequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the a d be detached f 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, page 2 should 24a. Was an has autopsy certificate Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of work? 1 🗌 Yes 2 🔲 No 1 Natural 5 Pending iniury Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, de 29b. Signature and title of certifier 28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AR. ADI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Beverly Joyce Frankenberry Nigh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 156 Heights Ave. Martinsburg, WV 25404 20c. Location - City or Town, State Waynesboro, PA 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Onset and Deat MINS 23d Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2**/X** No 1 ☐ Yes 201 No Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 6-24-11 368 ORIGINAL

3. Time of Death

Рм

8:20

9. Birthplace (State or Foreign

U.S.A.

14. Race - American Indian,

Black, White, etc.

Specify: White

10d. Inside City Limits

1 Yes 2 No

Registrar DHMH 17 Rev 7/2009 84

2011

ANTHONY J. NELSON 11-01787

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20

Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner March 5, 2011 1452 hrs Nelson Jerome Anthony 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8061 Croom Road Upper Marlboro Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of 7. Age (In yrs. last birthday) Funeral oreign Washington Country) DC Months Days Hours Director 577-08-8003 August 4 1980 1 X M 2 F 30 Yrs Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location MD Prince George's Greenbelt 1 X Yes 2 No 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 72. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7805 Mandan Rd. #201 20770 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes Specify: Black If Yes, Give Year 3 Widowed 4 Divorced Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Verizon Long Distant Technician Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claudia Ne1son Bobby Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Mandan Rd #201 Nelson / Mother Greenbelt, Md. Claudia 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 7/1/2011 Brentwood, Md Other Specify Donation 5 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Fundal Pervice Licensee Relia 20772 iaxas 3401 Bladensburg Rd Brentwood, Md. Part I. Enter 🖟 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line een Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last an and transit e Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death.

For the executed by the attending physician and etely filled in by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Year Fetal death Day Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 Yes , 2 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work' Certification: 2:52 And 12 pm Natural 1 Yes 2 X No Pending substect shot (Found) Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 9061 (1004) MOAD determined woods (tound (Specify) 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 16, 2011 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Ye.

32. Registra s Signata

			For State Registrar			nd / Depa		f Health	and Mental Hy	giene 0	1 21389		
	Dhunini	/	1. Decedent's Name (First, A	/iddle, Last)				, 2000.	2. Date of De		3. Time of Death		
and the same	Physicia Medi				rt Paul	Otto			June	27 20	11 1041 A M		
	Examir	ier	4a. Facility Name (If not institute 238 Douglas		number)		4b. City, Town	n, or Location o	of Death	4c. County of [
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		24 Hrs. 8. Date of Bir	Cecil of Birth 9. Birthplace (State or Foreign)			
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	th with ms 23 must	Funeral Director	238 Douglas	Street			2192	21		United	States		
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	오	Melvin Otto						lyn Bush				
Mar	shou h and 7 is m traum	Ŋ	19a. Informant's Name/Relat						r or Rural Route Numbe		Zip Code)		
	and 2 Healt tem 2		Jennifer E. 20a. Method of Disposition	Otto/Daugh			urso Dr			19711			
ШŌ	age 1 ent of nt: If i		1 ☐ Burial 2 🔀 Crema 4 ☐ Donation 5 ☐ Oth		m State	cemetery, crem	iatory or other p	Inc.	June 28,	20c. Location - City			
Baltimore,	permit. F Departm Importa any inju	Î	21. Signature of Funeral Serv		10,				Hicks Home		rals, P.A.		
<u> </u>	P a T a n	- 0	Wanud	. S. De	cho .	6911			ton Street		MD 21921		
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9289	tificate ng phy as the	Med	IF FEMALE:	_ <u></u>									
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Box	g e g	ysic 	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pre 9 □ Un	egnant at time of o known	death 5 ∐	Other (specify)	41		Month	Day Year		
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Re	: The la cate ha ; page	ទូ							_ perfo	rmed? death	Yes 2 100		
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of \	g Phy er this eral d	ے :e:	27. Manner of Death	28a. Dat	Inpatient 2 e of injury	28b. Time of	3 L DOA 28c. Inju	4 <u>□</u> Nur	sing Home 5 Resid	ence 6 Other (Sp ow injury occurred	ecify)		
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Division of Vital Records,	al or Attending Physician: Ti s after death. Il Director: After this certificat ed in by the funeral director, ps	Certificate:			e of Injury - At ho ding, etc. (Specify,		et, factory, office	9	28f. Location (S City or Tow	treet and Number or I	Rural Route Number,		
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	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Uneck 2 L Medic	al Examiner: On the b	asis of examination	n and/or investi	ation, in my opir	nion death occ	ace, and due to the cat curred at the time, date a and place, and due to the	ad place, and due to the	o ocupo(a) and mannor stated		
_ '	with a control of the		29b. Signature and title of cert		~			se number		29d. Date signed (Mo			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O Physician/ Tune 10:20M Doris Thelma Powers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown Washington Social Security Number Age (In vrs. last birthday Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 8-17-1918 Months Hours Min Mary land 216-10-8019 92 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at **Funeral Director** MD Rohrersville Washington 28a-f 1 Yes 2 No 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? 20422 Bent Willow Road 21779 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Insurance Co. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roland Watt Grabill Bertie Laurado Rippeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan H. Miller - Niece 10623 Green Valley Road, Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-25-2011 Brownsville Heights 4 Donation 5 Other (Specify) |Brownsville, MD 22. Name and Address of Facility Eackles-Spencer & Norton FH 21. Signature of Funeral Service Licensee Harpers Ferry, WV 25425 Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Ph, sician/ ARRYTHMIA disease or condition resulting in death) 25 mm Medical Due to (or as a consequence of) Examiner PHLURE DAYS Marian. Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit MONTH requires that the death certificate be executed CONGESTIVE WEARS FACURE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a d be detached f g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law certificate has autopsy performed? Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🕅 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After Natural 5 Pending Accident M 1 Tes 2 No Investigation within 24 hours after death

To the Funeral Director, and completed filled in by the items. 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 2011 クス 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOAD 11,90 mr JACONS DOWN 31. Date filed (Month Day) egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Day 201 Tear 7, 5:10 Рм John Lee Padgett Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Mary's Charlotte Hall Veterans Home Charlotte Hall Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours April 19, 1927 Mary land Director 220-16-8659 84 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Saint Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 29449 Charlotte Hall Road 20622 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0. Black, White, etc. þ 1 Never Married 2 Married 1 KM Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 XWidowed 4 Divorced WWII White Completed Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Bakery Be 17. Father's Name (First, Middle, Last) (unk.) 18. Mother's Name (First, Middle, Maiden Surname) $(\mathrm{unk}\,\centerdot\,)$ ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7677 Colonial Beach Rd. Pasadena, MD 21122 Harold Padgett / Son 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State June 10, 2011 Frederick, Maryland Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature Aral Service 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Ons an Death Moms Physician/ Medical Examiner Exceptibility list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a use as the burial-Physician/Medical P.O. Box 68760 nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was de 23d. Date of delivery 3 🗌 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy performed certificate 2 - No 1 Yes Division of Vital Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 I this 24 hours after death.
Funeral Director; After thi eted filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work Accident Investigation М 1 Tes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one 29b. Signatur and title 29d. Date signed (Month,

State Registrar

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(x)

29449 Charlotte Hall Rd., Charlotte Hall, MD 20622

npleted cause of death (Item 23a) (Type, Print)

accard.

Calley, M.D.

JUN 2

31. Date filed (Month, Day, Year)

Registrar

State

10294 Registrar's Signature Athabasca Tr. New Market MP

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dules

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Lillie Mae Suggs Proctor 201 I 14 2105 hrsM June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 2518 Van Buren Street Hyattsville 8. Date of Birth 1919 (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Director 91 579-20-3770 December 18 Maryland Usual Residence of Decedent 28a-f shov 10a. State the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 20782 2518 Van Buren Street United States items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 9 þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working th and Mental Hygiene.
It is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.Dept. of Navy Computer Programmer vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 pe Willie Minnie Thompson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Suggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Proctor Lloyd (Daughter) 2518 Van Buren Street; Hyattsville, Maryland 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 27,201 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery Suitland, Maryland Signal re Funeral Servi 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ arriver apres Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter or denying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
24 hours after death.
25 hours after this certificate has been signed by the attending physician and a the and in by the function director, page 2 should be detached for use as the burla-transit Severe mitral that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 month 1 Yes 2 No Pregnant at time of death Month Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Pulmonale 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛮 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0101232868 June 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1715 North George Mason Drive; Suite 306

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State

Registrar

Arlington, Virginia

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Physicia Medic		1. Decedent's Name (First, Middle, Last) EDITH PEARL RYAN 2. Date of Death Month Day Year JUNE 17, 2011													Year	3. Time of Death		
Examin	er	4a. Facility Name (if SAFE HAVE 5. Social Security No.	ast birthday)								of Death ANN 9. Birth	NE S						
Director	<u>_</u>	220–26–1] Usual Residence of 10a. State	1 □ M 2 X) F	F 93 Yrs. Months Days Hours Min. 10/24/1917							7	MARY	ntry) (LAND) 10d. Inside City Limits					
the Marylar or 28a-f s e notified	Director	MD QUEEN ANNE 'S 10e. Street and Number					ENSTO	Vhat Cou	1 XYes 2 □ No									
s 23a	Funeral	108 GREE	ENWOOD	CREEK RD											NITED STATES			
fled within 72 hours after death with the Manyland death Hygiene. d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give							dent of His			ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify:				
	lete		15. Deceder	nt's Education			16a. Dece	dent's Usu	al Occupa	ation			16b.	Kind of Bu	LSiness Ir			
e filed within 72 houn tal Hygiene. ed other than "natu event, the Medical	Sompleted		(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)						live kind of work done during most of working by DO NOT use retired) AIMS EXAMINER							INSURANCE		
a 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than r other traumatic event, the M	To Be	17. Father's Name (F		.ast)								e (First, Middle, CHEELER		n Surname	e)			
should and N is ma auma		19a. Informant's Na	me/Relationsl	nip (Type, Print)			19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	l Route Numbe	er, City	or Town, S	tate, Zip	Code)		
and 2 stealth sealth sear 27		JEAN ELL		ON						CRE	EK R	D. QUEE	NST	OWN,	MD 2	21658		
permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation	Cremation 5 Other (S		om State	C	lace of Dispo emetery, crei	E CR	ther place	ON	6-20-	Date -2011		Location -		Town, State		
Depar Impo any ir once		21. Signature of Fur	uca	MA. W	lle	ina	<u> </u>	30 SI	S, H EER	ELFEI ROAD	OBEI!	N & NEW STERTOW	Ν,	FUNE MARYL	RAL AND	HOME, P.A. 21620		
Physician/ Medical Examiner	١.	23a. Part 1. Enter the disease, or complication that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions.												+	Approximate Interval Between Onset and Death			
	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):																
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Hospital or Attending Physician: The law requires that the death certificate be At hours after death. Funeral Director: After this certificate has been signed by the attending physici ated filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 2 9 ☐ Unknown								e of deliventh	very Day Year							
uires tnat t n signed b uld be deta	by	23e. Did tobacco use contribute to																
The law req ate has bee page 2 sho	Completed	24a. Was an autopsy prior deat												rior to co leath?	opsy findings available ompletion of cause of			
clan: ertific ector,	Be	25. Was case referre examiner?	2171	Hospital:				26. Place of Death (Check only one)										
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ms		30. Name and addre	Ann.	ABAL,	114.	H,D	23a) (Type, F	Print)	to S	tree	+,	Cheste	160	wn	,74	ed 21620		
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DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21 Per FH C917 7/17/2011 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris Ann Sabine 7:00Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 67 Sunbrook Lane Washington Hagerstown 5. Social Security Number 8. Date of Birth 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign CA 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. May 15, 1944 1 M 2 XF 547-70-7353 Director 67 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 67 Sunbrook Lane 21740 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Narried þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Accounting Tax Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lerov Calvin Carroll Charlotte_Allan Fraser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Health em 27 625 Third Ave., permit. Page 1 and 2: Department of Health Leroy A. Lynn / Son Atglen, PA 19310 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematorium 06/23/2011 Smithsburg, MD 21. Signature of Funeral Service Licensee per DVR 22. Name and Address of Facility Gerald N. Minnich Funeral Home Bryan K. Kenworthy M01282 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cardiovascular Atheroscleratio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Resonchitis Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 🗌 Yes 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 \square No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D47234 June 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-15 13424 Pennsylvania Ave., Hagerstown. Dr. Kelli Strauss, M.D. 31. Date filed (Month, Day Yes) State Barka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day CHARLES L. SCHELBERG 2011 JUNE 19 6:40 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GILCHRIST CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min Month, Day, Year) Y 25, 1925 1 **X** M 2 □ F Months 219-14-1159 DELAWARE Yrs Director 86 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director QUEEN ANNE'S QUEENSTOWN MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21658 7119 FIRST AVENUE 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates WW II 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) BANKING BANKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CHARLES L. SCHELBERG IDYLETTE BATTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8024 RIDER AVE., TOWSON, MD 21204 CHARLES B. SCHELBERG/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) JUNE 23, 4 ☐ Donation 5 ☐ Other (Specify) OLD WYE CEMETERY WYE MILLS, MD 2011 Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition cari Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transil the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 410 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) 24 hours after death. **e Funeral Director:** After this lated filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Grifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis or examination allows investigation, in this opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 3 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 41000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+1

Registrar

State

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31. Date filed (Month, Day, Year)

KUMAR

2011

JUN 21

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 201T PEARLE STARKEY **EMMA** 5:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death CENTREVILLE CORSICA HILLS NURSING HOME **QUEEN ANNE'S** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** nth, Day Days Hours Director MARYLAND 214-42-8100 85 FEB. 1926 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD QUEEN ANNE'S 1 Yes 2X No QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21658 125 MAINBRACE DRIVE USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ESTELLA R. RUSSUM ROBERT D. DILL, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is VIRGINIA S. LEWIS/ DAUGHTER 307 HOLLY ST., CENTREVILLE, MD 21617 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or CHESTERFIELD CEMETERY JUNE 22, CENTREVILLE, MD . Signature of Funeral Service Licensee 22. Name and Address of Fa FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LIBERTY ST., CENTREVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final Or set and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 10ars The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Dav Year Pregnant at time of death
Unknown 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe After this certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician; To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Hospital Medical 1 X ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check dat the trive date and plane, and due to the courses) and name or as states 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (H m 23a) (Type, Print) 3 31. Date filed (Month, Day, Yes State

Registrar

JUN 2 0 2011

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erence Sweene	•	St 1- For State Registrar	ate of Maryla		artment of		nd Mer	ıtal Hyg		g. No.		21399
Physicia Jedical Examir	n/	1. Decedent's Name (First, Midd Terence LeBa	,	eney					Date of Death Month June 24, 2	n Dav	Year	3. Time of Death 0337 hrs
		4a. Facility Name (if not institution St. Marys Hospital				4b. City, Town, o					inty of Death	
Funeral Director		5. Social Security Number	6. Sex	7. Age (in yrs.	last birthday) Yrs	If Under 1 Ye Months Da		Min.			Foreig	unto d
any		215-70-8872 Usual Residence of Decedent 10a. State 10b. County	1 <u>23</u> W 2F	54 10c. City	, Town or Locat		_l		12/10/	1956		Maryland 10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	Director	Maryland St. Mar 10e. Street and Number		Ho11	ywood	10f. Zip Code			10	g. Citizen o	of What Cour	1 Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. icm 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	- L	43839 Mustang 11. Marital Status 1 Never Married 2 M	12. Was Dec Armed F 1 Yes	2 X No	lf Y	20636 s Decedent of H es, specify Cuba	n, Mexican	, Puerto Ri	ify Yes or No-	14. F	Stat Race - Ameri Vhite, etc.	es can Indian, Black,
72 hours after na "natural",	ompleted by	3 Widowed 4 X Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)	orced If Yes, Give Yes or Dates: cify only highest gra-	de completed)	16a. Deceden	Yes 2 X No t's Usual Occupa ost of working life	ation (Give	kind of wor		Speci 16b. Kind o	of Business/i	<u>ite</u> ndustry
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "nature e event, the Medical Exami	Be Comp	12 17. Father's Name (First, Middle,			Techni	cian			irst, Middle, M	Heati laiden Surna	ng an	d Air
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other timingry or other traumatic event, the Med	2	Cornelius Swee 19a. Informant's Name/Relations Elisa Sweeney/	hip (Type, Print)		Гр.о.в	Address (Stre	et and Nur	wood.	al Route Numi	0636.		
Baltimore, permit. Pages I an Department of Hea Important: I ites		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Sa	pecify:	om State	Place of Dispos crematory or oth insfiel	ner place)	. Cma	06/20	Date 0/2011	Ob 1	otte	H 11 M
Physician	- 1	21. Speaton of funeral Service Edward N. Bring 23a. Part I. Enter the disease, or	11	M0005 Mused the death	22. N 22 1. Do not enter the	ame and Addres 955 Holl ne mode of dying	SS of Facility WOO	Brin: 1 Road ardiac or re	sfield d. Leor	Funer	al Ho	me, P.A. D. 20650 Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Hypert</u> e		Atherosc							Between Onset and Death
	miner	Sequentially list conditions, if any library to immediate cause. Enter Underlyin Cause	b to for as #	confequence o	00)							
asit ed	Exa	(Disease or injury that initiated events resulting in death) Last	d	23a,27,		~017 7 7	7 3 1	~				
arici pe		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes,	outcome of preg oirth nant at time of de	nancy	al death 3		c pregnanc	y	23d. Date Mont	e of delivery th D	ay Year
res that the disigned by the be detached	ক্র	Part ii. Other significant condit			esulting in the u	nderlying cause	given in Pa	art I.				the cause of death?
Records, The law requir ficate has been s	Completed								24a. Was a autops perform 1 Yes 2	y ned?		topsy findings available completion of cause of
FVITAL Re- Physician: The r this certificate al director, page	e Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2		3 DDA	Dther ₄	(Check only	lome 5 F	Residence		
Afte After	Certification:	3 Suicide 6 Coul	ling tigation	or injury , Day,Year) e of Injury - At h	28b. Time of Ir	1	Yes 2 building, et	No	d. Describe he f. Location (St or Town, Sta	reet and Nu		al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only 1 Certifying Pt	nysician: To the best niner:On the basis and manner s	of examination a								
	Ž	29b. Signature and title of certifie				29c. Licen: O.C.	se number M.E.			29d. Date s June 24		ith, Day, Year)
			istant Medical t	Examiner 9	900 W. Balti	more Street,	Baltimo	re, MD 2	21223			
Sta	te	31. Date filed (Month, Day, Year)	2011	egistrar's Signatu	Land	Les .						

			1 - For State Registrar	State of I	Marylar		artment <i>tificate</i>			and M		jiene eg. No.	201	Section Assessment	21	400
I	Physici	an	1. Decedent's Name (First, Middle, Las		orence	e Louel	la Sm	ith			2. Date of Dea Month	Day	, 20°		3. Time o	
1	/Medi Examir		4a. Facility Name (If not institution, give						Location o	of Death	June	27 4c.	County of E		3:22	A
7	Exami	iei	Golden Living		.,		,,		gerst						gton	
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under		If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day	Voarl	9.	Birthpl	ace (State	or Foreign
	Director		219-36-3462	□M 2[X]F	94	Yrs.	Months	Days	Hours		Nov. 18				nsylv	
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	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23s or 28s-f show its Medical Examilier must be notified at	ō	Maryland Washi	ngton	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,		thsl	ourg							2 XNo
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic event, if a Medical Examiliar must be notified at		19a. Informant's Name/Relationship (18 Betty Lou Leather		ter)						Route Number					
altimore,	permit. Pages 1 and 2: Depertment of Health at Important: If Item 27 ie eny Injury or other trau		20a. Method of Disposition		1 6	Place of Dispo	sition (Nam	e of	a)	D.	ate 30,	20c. Lo	ation - City	or To	wn, State	
Ĕ	Pages nent of ant: If its ury or o		1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		II.O	thsbur					11	Smi	thsbu	rg,	Mary	land
alt	Depertit Import eny Inje		21. Signature of Funeral Service Licen	500	MO	1272	. Name and			•	J.L. Da					
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Box	leath certifica attending pl	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-					2	3d. Date of	delive	ry	
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0	tending leath. tor: After the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	Day Year)	Injury	м	Bc. Injury Work	(?` Yes 2 □ N		04. 06301106 111	J 10 11 11	COCCITOC			
Division	or Attending Physician: ofter death. Director: After this certifici in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At he etc. (Specif	ome, farm, str y)	eet, factory,	office		2	8f. Location (S City or Town		Number o	r Rura	l Route Nut	nber,
	To the Hospital or Attence within 24 hours efter death To the Funeral Director: completely filled in by the		29a. Certifier 17 Certifying Ph	ysician: To the be	est of my kno	wledge, death	occurred a	at the tim	ie, date and	d place, a	nd due to the c	ause(s)	and manne	er as st	ated.	
	the H iin 24 the Fu	ledicai	(Check only 2 Medical Examone)	and manner	s of examina	tion and/or in	estigation,	in my op	oinion, deat	tn occurre	d at the time, d	ate and	place, and	due to	the cause	s)
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			- Manje	1 gg	raj			PZ	365			6	28	- /	1	
			30. Name and address of pers in who	completed cause of	of death (Item	n 23a) (Type,		1001	2 64	4	- Ela	00	,	10		1790
	Sta	te.	31. Date filed (Month, Day, Year)	32. Rea	istrar's Signa	36	8 n	me	51	vell	HOL	381	em	Pay	U. Ll	140
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 T Janeva Florence Tisinger June 4:51 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1411 Potomac Ave. Washington County Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day Country)
West Virginia 1 □ M 2 🂢 F Days Hours Director 227-22-5211 86 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1411 Potomac Ave. 21740 U.S.A. should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Baltur...

permit. Page 1 and 2 should by Bepartment of Health and Mental Hygiens.

Containt: if item 27 is marked other than "nature,"

Ather traumatic event, the Medical Exe 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commission on Aging Site Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bohrer Bertha Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janeva Cool-daughter 14508 Edgemont Rd. Smithsburg, MD 21783 Baltimore, 20a. Method of Disposition

1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jackson Cemetery 6-25-2011 4 Donation 5 Other (Specify) Mt. Jackson, VA 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Contrying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature completed cause of death (Item 23a) (Type Prin State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2011 June 1407 PM Celius W. Thompson 14, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 6. Sex Age (In vrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours Min Feb. 2, 1933 Director 214-28-5354 78 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "--- any injury or other than the state of the ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🛢 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10020-203 Stedwick Road 20886 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: If Yes, Give Year or Dates Specify: 3 Nidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Kitchen Designer Lumber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leroy Thompson Irene Lundenbeil Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrician A. Thompson, Wife 10020-203 Stedwick Road, Montgomery Village, Maryland 20c. Location - City or Town, State 20886 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metropolitan
Crematorium, Inc. 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) June 17, 2011 Alexandria, Virginia 21. Signature of Funeral / ice Licens 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Chronic Obstructive Pulmonary Disease Years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a conse uence of ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 🗌 No 9 I Unknown signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Retro Peritoneal Hemorrhage 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acute Renal Failure certificate has b lirector, page 2 s autopsy performed? Yes 2 N 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death completed filled in by the 24 hours a Funeral I within 2 To the I

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MO D0053317 June 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 Frederick Road, #213, Gaithersburg, MD 20877

State Registrar Ball,

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Brilian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 9 Day KATIE TILLERY В. JUNE 2011 11:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAY RIDGE HEALTH CARE CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕱 F (Month, Day, Min. NORTH CAROLINA **Director** 229-44-0914 77 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6228 WOLVESTON LANE 20735 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married <u>ک</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental He filed filed of Health and Mental He filem 27 is marked of မ JOHN TILLERY CORA ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELMA T. SMITH/SISTER WOLVESTON LANE CLINTON, MARYLAND 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Page 1 nportant Burial 2 Cremation Removal from State WASHINGTON NAT'L CEM. 6/28/2011 onation 5 Other (Specify) SUITLAND, MARYLAND any injury Funeral Service Lie 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signatu 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ardinascular Discona disease or condition resulting in death) Medical Due to (or as a consequence of) _ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). Exami The law requires that the death certificate be executed Due to (or as a consequence of) nding physician use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 m 1 \(\text{Yes} \) 2 Ectopic pregnancy Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellother 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be completed filled in by the funeral director 26. Place of Death (Check only one) Other: 1 🔲 Yes 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation Could not be 2 Acciden
3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 30063641 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 UNIVERSITY BLVD E # 208 HYATTSVILLE, MARYLAND 20783 AJIT KURUP M.D. 31. Date filed (Month, Day, Year)
JUN 2 2 2011 32. Registra

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviand Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2^y011 June 24. 6:00 P M Bruce Thomas, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Fort Washington Hospital Fort Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 578-68-3042 **Director** 1950 Washington, DC 60 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be Funeral U.S.A. 20603 8900 Twinbrook Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry GSA/ Elementary/Seconday (0-12) College (1-4 or 5+) the U.S. Government Building Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be file of Health and Mental H if item 27 is marked of ir other traumatic even Arthur Stewart Thomas, Sr. Mary Eva Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra K. Thomas 8900 Twinbrook Court Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If its
any injury or of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 6/30/2011 Waldorf, MD Trinity Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Raymond Funeral Service, 5635 Washington Ave., La Piata, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. tue: Arren trils certificate has been signed by the funeral director, page 2 should be detacted. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ပ 1 Tes 1 🗌 Inpatient 2 🌉 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10905 Fort Washington Rd. Suite 206 Fort Washington, Md. 20744 Paul A. Bone 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pieas 1 _ For State	State of M		/ Depa	artment of I	Health and I		•	gible.	01105
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,	Last)			tificate of I	<u>Jeatn</u>	Date of Dea Month	Day	Year	3. Time of Death
Medic Examin	al	4a. Facility Name (if not institution,		^	Vick.		r Location of Death	06	4c. County		0345AM
Funeral		5. Social Security Number	ealth Care 6. Sex 1 \(\text{M} \) 2\(\frac{1}{2}\(\text{F} \) 7. Ag	e (In yrs. lasi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9. Birthp	lace (State or Foreign
Director		578-14-7692 Usual Residence of Decedent	1 L M 2 & F	93	Yrs.		Thous I will.	Dec. 8	1917		ÿland
/aryland 8a-f shc tified at	rector	10a. State 10b. County Maryland Washi	ington		Town or Loc agers					11	0d. Inside City Limits 1 ☐ Yes 2 ※ No
vith the M 23a or 2 st be no	Funeral Director	10e. Street and Number 11403 Stonecro	oft Ct.			10f. Zip Code 2174	2		10g. Citizen of		try?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🖪 Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S.	If		Iispanic Origin? (Span, Mexican, Puerto Specify:		Bla	ce - America ck, White, e	etc.
thin 72 hour sne. than "natu he Medical	Completed by	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education		(Give F life, D	lent's Usual Occup kind of work done D NOT use retired) emaker	during most of work	king	16b. Kind of E	own h	
d be filed wi Mental Hygis arked other artic event, t	To Be (17. Father's Name (First, Middle, La Charley Kunkle	est)				1	ne (First, Middle, I na Uglow	Maiden Surnam	e)	
d 2 shoul alth and I 27 is ma r trauma		19a. Informant's Name/Relationship Nelson H. Vick,					and Number or Rur Valley Dr				
Page 1 an nent of He ant: If item ıry or othe		20a. Method of Disposition 1 ☐ Burial 2 🗵 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		cen	netery, cren	sition (Name of natory or other pla vn Cremat		Date 22/11	20c. Location	-	wn, State Maryland
permit. Departi Import any inji		21. Signature of Funeral Service Lic	nensee Muz	mi	$\langle 1 \rangle$	Name and Addre	ess of Facility M	INNICH F			21740
hysician/ Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)	a. Adulance Due to (or as	ad Vo	SCLL)	_	entra w	ith De		hoi	Approximate Interval Between Onset and Death
be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):		Diseas				
ate be ex ohysician the burial	cal		d. Chron	(C)	ostr	retive	Pulmon	sary Di	Sease	-	
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. within 24 hours after death. to the Funeral Director. After this certificate has been signed by the attending physis completed filled in by the funeral director, page 2 should be detached for use as the to the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal of	death 3	Ectopic pregnan Other (specify)	су			ate of delive	ery Day Year
requires that the death been signed by the atte should be detached for		Part II. Other significant condition Hypothypoidi		_		_	ven in Part I.				e cause of death?
rsician: The law req s certificate has bee lirector, page 2 sho	Completed by							24a. Was a autop: perfor 1 Yes	sy med?		osy findings available mpletion of cause of 2 XNo
s certific	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 F	B/Outpatien	26. P	lace of Death (Chec	ck only one) ome 5 \square Reside	anaa 6 🗆 Ott	or (Specify)	
ding Phy h. After this funeral c		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of inju (Month, Day	ry 2	8b. Time of injury	28c. Injur wor	y at	28d. Describe ho			
to the Hospital or Attending Physician: the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director,	Il Certificate:	2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	ot be 280 Place of Inju		e, farm, stre		i les Z 🗆 NO	28f. Location (St City or Town		er or Rural	Route Number,
n 24 hour	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e	xamination a	nd/or invest	igation, in my opini	on, death occurred a	at the time, date ar	nd place, and du	ie to the cau	use(s) and manner stated
To the		29b. Signature and title of certifier	raden-Ble	ucher	CRN	29c. Licens	e number	2	29d. Date signe	d (Month, E	Jay, Year)
J-Z		30. Name and address of person w	ho completed cause of d		3а) (Туре, Р РNР	rmt) - 333 17	ill Stree	t, Have	stown	0, MC	21740
Stat Registra		31. Date filed (Month, Day, Year)		ar's Signatur		harle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		epartment of Certificate of			601	2 406
	Physicia	ın/	Decedent's Name (First, Middle, L.)	_ast)				2. Date of Death Month	g. No.	3. Time of Death
	Medic Examin	cal	LEONA 4a. Facility Name (if not institution, g		ODS	4h City Tayra	or Location of Death	June	· · · · · · · · · · · · · · · · · · ·	(ear 2:00 A M
	EXAMI	lei	Frederick Mem	·	tal		erick		4c. County of Frede	
	uneral irector		215-26-0878	. Sex 1 □ M 2 🛛 F	e (In yrs. last birtho	day) If Under 1 Years. Months Day		8. Date of Birth AUG • 18 • 19	928	9. Birthplace (State or Foreign Country) Aary Land
and	show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Maryla	28a-f	irect	Maryland Frede	rick	Bruns	swick				1 ☐ Yes 2X No
with the	is 23a or nust be n	Funeral Director	10e. Street and Number 3904 A, Peter	sville Rd.		10f. Zip Code	1716		g. Citizen of Wh J nited S	· ·
036 rs after death	coparinent or result and wented raybene. The man are stated other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	d 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
15-C	n "natu ledica	Completed	15. Decedent's (Specify only highest		(Decedent's Usual Occ Give kind of work ddn	during most of work	ing 16	6b. Kind of Busi	ness Industry
212 within	er than	Con	Elementary/Seconday (0-12)	College (1-4 or 5	+)	fe. DO NOT use retire L neworker	a)	A	Americar	n Optical
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after peartment of Health and Mental Hoviene.	ked oth	To Be	17. Father's Name (First, Middle, Las Lee McCle11				18. Mother's Nam	ne (First, Middle, Mai	iden Surname) Smith	
Marylance of 2 should be file alth and Mental I	is mar		19a. Informant's Name/Relationship	,		Mailing Address (Stree	et and Number or Run		ity or Town, Stat	
e, R and 2 Health	ther tr		Joseph May III,	Grandson	_	7 Yeagerto				
Page 1	ant: If it		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery,	crematory or other pi	ace)			ity or Town, State k, Maryland
Balti permit.	Importa any inju		21. Signature of Funeral Service Lice	ensee to top.	1	22. Name and Add	ress of Facility Sta th Maple A	uffer Fun	neral Ho	omes, P.A.
Exa	sician/ ledical aminer	Examiner	23a. Part 1. Enter the disease, or conshock, the heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a		UMIOI		or respiratory arrest,		Approximate Interval Between Onset and Death
760 cate be execute	physician and the burial-transit	edical Exar	Cause (Cisease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of)	:				
. Box 6876		Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)	ncy		23d. Date of Month	· ·
Is, P.O	d pe deta	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying cause	given in Part I.			ute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.	certificate has bee lirector, page 2 shou	Completed						24a. Was an autopsy performe	ed? pric	re autopsy findings available or to completion of cause of atth? Yes 2 \sum No
ital sician:	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		l Ot	Place of Death (Chec			
of V	ter this	te: To	27. Manner of Death	28a. Date of injur (Month, Day,	nt 2 ER/Outp y 28b. Tin Year) inju	ne of 28c. Inju	4 □ Nursing Ho	ome 5 Residence 28d. Describe how		Specify)
ion ttendir death.	tor: Af	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	ion		M 1 [Yes 2 ☐ No	· · · · · · · · · · · · · · · · · · ·		
Divis alor A safter	al Direct		4 Homicide determine	building, etc.	ry - At nome, farm . (Specify)	n, street, factory, office		28f. Location (Stree City or Town, S		or Rural Route Number,
ne Hospit	ne Funera	Medical	Check 2 L Medical Exa	hysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination and/or i	nvestigation, in my opir	iion, death occurred a	t the time, date and r	place and due to	the cause(s) and manner stated
To th	To th		29b. Signature and title of cortifier	7		29c. Licen	se number	29d	I. Date signed (A	Month, Day, Year)
			30. Name and address of person who	o completed cause of de	ath (Item 23a) (Tu	De Print)	061410		June,	, 16, 2011
Q	3		GAFFAR	SYED	801	Tou th	ousE,	Frede	rick	MD
F	Stat Registra	_	31. Date filed (Month Day Year)	2011 32. Registrar	's Signature	ge, death occurred at 29c. Licen Do pe, Print) Tocc He				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienea State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ SUSAN 26^{Day} ROSSER WOODRUFF JÜNE 2011 8:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7470 MASON SPRINGS ROAD LA PLATA CHARLES Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours (Month, Day MAR . 31 . 1<u>947</u> 1 M 2 XF VIRGINIA **Director** 227-68-3262 64 Usual Residence of Decedent show 10a. State or 28a-f shown notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 7470 MASON SPRINGS ROAD 20646 U. S. A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 0 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) FACILITIES MANAGER I INTERNATIONAL Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o ္ဝ Page 1 and 2 should be EDWARD B. ROSSER LEAH A. HENDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS P. WOODRUFF/HUSBAND 7470 MASON SPRINGS RD, LA PLATA, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot JUNE ate 1 Burial 2X Cremation 3 Removal from State METRO - CREMATORY 28, 2011 4 Donation 5 Other (Specify) ALEXANDRIA, VA Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ wormsing disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available 24a, Was an certificate has autopsy prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury Accident 5 Pending I Director: And in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) within 24 hours a 29a. Certifier 🔁 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Je the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: only one 29b. Signatur e number

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ROCKVIL HOSPITA. ADVENTIST MONTGOMERY HADY GROVE 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 💢 F Country) INDIA Months Month, Day, 7 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD MONTGOMERY BOYDS 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2084 8309 FABLE TNDIA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 Yes If Yes, Give Year or Dates. ASIAN 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) HOME OWN MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 40019a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FABLER DR. BOYDS 18309 SUF SEN-IN-LAN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **★**Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other, p 6/20/2011 FREDERICK MD ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER. 21. Signature of Funeral Service Lice T. WOODBRUGE VA 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the "Itending physician and signed by the tending physician and de detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 **X**N Yes Yes completed filled in by the funeral director, 25. Was case referred to medical BB 26. Place of Death (Check only one) examiner? Other: 2 No 유 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) m.D. D0065505 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DR. ROCKVILLE, MD. 20850 31. Date filed (Month, Day, Year) State 2 2011 JUN 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of IV	iai yiai		tificate of			vieritai my	/giei Reg. i	2011	21409
H	Physicia Medi		1. Decedent's Nam	, ,	est)	ABF	RAMOFF				2. Date of De Month	eath	Year 2011	3. Time of Death 6:26 PM
سيماله	Exami		4a. Facility Name (if	not institution, giv	e street and number)			4b. City, Town	, or Locati	on of Death	12007		4c. County of Deat	
Agran d	·			DALE HEBI				BALTI					N/A	
Ē	Funeral Director		5. Social Security N 111-22- Usual Residence of	3410	Sex 7. Ag	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Day		der 24 Hrs. S Min.	8. Date of Bi (Month, D 01/17		9. Birt Cou	hplace (State or Foreign intry) NY
	yland f show ed at	tor	10a. State	10b. County		10c. Cit	y, Town or Loc	cation						10d. Inside City Limits
	Mar 28a-	Director	MD	BALT	IMORE		PIKES	VILLE						1 🗌 Yes 2 ื No
	s 23a or	Funeral [10e. Street and Nun	LD COURT	ROAD			10f. Zip Code	1208			10g. (Citizen of What Co USA	untry?
36	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾		ied 2 🛣 Married	12. Was Decedent Armed Forces? 1 🖾 Yes 2 🗆 If Yes, Give			Vas Decedent of Yes, specify Cu			ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	
9	atural	etec	3 🗆 Widowed	4 U Divorced 15. Decedent's E	Year or Dates.			ent's Usual Occ		y.			Specify:	WHITE
21215-0036	nin 72 h ne. than "n e Medi	Completed	(Spe Elementary/Seco	cify only highest gi	rade completed) College (1-4 or t	ō+)	(Give k life. DC	ind of work don NOT use retire	e during n d)			16b.	Kind of Business I	
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ary	should and M is ma		19a. Informant's Na	me/Relationship (7			19b. Mailin	g Address (Stree					or Town, State, Zip	
	1 and 2 should be fi f Health and Mental item 27 is marked other traumatic ev			ABRAMOFF/	SON		121	43 WOOD	SYDE	COURT	, OWING	GS N	MILLS, MD	21117
more	Ο				Removal from State	C	emetery, crem	sition (Name of atory or other pi HEBREW			Date		Location - City or	
Baltimore,	permit. Page Department of Important: If any injury or once.		21 Signature of Fur	neral Sernice Vice		_ DAL	22.	Name and Add	ress of Fa	cility SO	L LEVI	NSON	REISTERST N & BROS.	, INC.
	_		23a. Part 1. Enter th	ne disease, or com	plications that caused	the death	n. Do not ente	the mode of dy	ing, such	STOWN as cardiac o	ROAD, I	PIKE	ESVILLE,	MD 21208
المد	Physician/ Medical		Immediate Cause (F disease or condition resulting in death)	t tallure. List only d Final	a. ATHE	nos	cieno	Tle CA				_	SEASE	Interval Between Onset and Death
A. S. Carrier	Examiner	<u>.</u>	Sequentially list con	nditions.	Due to (or as a	a consequ	ence ot):		_					
	nted d ansit	Examine	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	injury	Due to (or as a	a consequ	ence of):							
_	ificate be executed g physician and as the burial-transit		that initiated events resulting in death) L	ast	Due to (or as a	a consequ	ence of):			-				
8760	ficate I g phys	dedical			d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death certiful 24 hours after death. To the Leneral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent print the past 12 mm 1 Yes 2 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic pregna Other (specify)	ncy				23d. Date of deli	very Day Year
P.O.	that th gned by e detac	by Ph	Part II. Other signific	cant conditions o	ontributing to death b	ut not resu	ılting in the un	derlying cause of	given in Pa	art I.	23e. Did t	obacco	use contribute to	he cause of death?
rds,	v requires been sig should b	eted									1 🗆	Yes 2	2 No 3 Pro	bably 4 Unknown
Division of Vital Records,	Physician: The law r r this certificate has b rral director, page 2 sh	Completed									24a. Was auto perfo 1 Yes	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
ta	cian: ertific ector,	Be	25. Was case referred examiner?		Harris de la companya della companya della companya de la companya de la companya della companya			26. 1	Place of D	eath (Check				
<u> </u>	Physic this c	일	1 Yes 2 2 27. Manner of Death	No	Hospital: 1 Inpatie		R/Outpatient						6 Other (Specif	y)
o uoi	eath. or: After the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not be	(Month, Day	Year)	28b. Time of injury	28c. Inju wo M 1 [ry at rk? Yes 2		28d. Describe h	now inju	iry occurred	
Divis	e Hospital or Attending Pt n 24 hours after death. he Funeral Director: After th pleted filled in by the funeral		4 Homicide	determined	building, etc	. (Specify)					City or Tou	vn, Stat		
	the Hosp nin 24 hor the Fune	Medical	(Check 2 l		sician: To the best of r ner: On the basis of ex se Practioner: To the b	amination	and/or investig	ation, in my onin	ion death	occurred at	the time date a	and plac	e and due to the ca	use(s) and manner stated
	0 N With		29b. Signature and ti	tle of certifier	llon un	so.		29c. Licens					ate signed (Month,	
			30. Name and addres	ss of person who c	ompleted cause of de	ath (Item 2	23a) (Type, Pri	nt)	σ7 x /z	י נפטרי	5 AV	R	h Cidenal	5, m) 21215
	Stat	e	31. Date filed (Month,	Day, Year)	2. Registral	r's Signatu	LA DA	10.77	- WVC	- V-C	- 114.7	الر.	4 more	1000
	Registra	r	1111	0 7 2011	15.		BAK							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 3:20AM BENJAMIN AMBUSH 2011 HOMAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FLEDERICK WALKERSVILLE CENTER GLABE VALLEY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) FLEDERICK Days Hours Months 1 M 2 □ F 94 217-01-6112 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, It a Modical Examinar must be notified at 1 ☐ Yes 2 No FREDERICK MO PREDERICK Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ROAD USA HOPELAND 21704 3556 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Specify: BLACK altimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", or Specify: 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US 60V. filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COURIER 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Iten 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be tmbush SARAH HARRISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5309 IVYWOOD NORTH FREDERICK MO FOREMAN CLARICE 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Mem 20c. Location - City or Town, State 20a. Method of Disposition Gas July 6, 2011 Frederich md Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY Li RULUNS PUN. Item C 21. Signature of Funeral Service Licensee WEST SOUTH ST FREDERICH MO news 2. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 🛛 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 2 No 1 ☐ Yes investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43091 7-6-2011 House Ave, Frederick, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 TOLL MID Zardi Saced

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 950 AM Michele Alex Barrett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rosedale FRANKLIN Quase HOSPITal Timore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 3, 1952 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Maryland 219-52-5870 **Director** 59 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Meadow Road 21206 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ρ 1 Never Married 2 XMarried 2 X No 21215-0036 Yes 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: <u>.</u> 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Insurance Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Investment Co. 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Peter Alex Anne Rose Mangan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Barrett/Spouse 500 Meadow Road, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) of Faith Cem. 7-9-11 Baltimore, Maryland 22. Name and Address of Facility
McComas Funeral
1317 Cokesbury Home P.A. Rd. Abingdon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine bunial-transit Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 2 No Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioned: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print) Baltmore 31. Date filed (Month, Day, Year) 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

07

2011

lizabeth P. Bei	nser	State of Maryland / Departm			2011 2141:
			ate of Death		ZUII ZI41, g. No.
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Elizabeth Perger Benser		2. Date of Death Month	Day Year
nourour Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locati	June 26, 20 ion of Death	4c. County of Death
		Upper Chesapeake Medical Center	Bel Air		Harford
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		ours Min	(MM/DD/YYYY) 9. Birthplace (State or Foreign
Birector		160-20-1982	Yrs.	Feb. 23	3, 1926 Pennsylvania
' any		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
Maryland 28a-f show d at once.	tor	Maryland Harford Joppa			1 Yes 2 Xino
5-0036 led within 72 hours after death with the Maryland dygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner, must be notified at once.	Director	1001 Pine Pard	10f. Zip Code 21085	109	g. Citizen of What Country?
with the ns 23a se noti		1001 Pine Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic	Origin? (Specify Yes or No-	USA 14. Race - American Indian, Black,
r death or iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexic		White, etc.
rs after ural", miner	Ď	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 No spec		Specify: White 16b. Kind of Business/Industry
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO N		TOD. Kind of Business/Industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	D D		Homemaker		Own Home
15-(Be	17. Father's Name (First, Middle, Last) (UNK) (UNK) PERGER		ther's Name (First, Middle, Ma JNK) (UNK)	
D 2121(should be fill and Mental H 7 is marked	일			, , , , , , , , , , , , , , , , , , , ,	(UNK) er, City or Town, State, Zip Code)
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Ore, ges lages la t of He		1 Burial 2 Cremation 3 Removal from State cremat	of Disposition (Name of cemetery, tory or other place)		20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite Injury or other tr		4 Donation 5 Other Specify: Highvi	Lew Memorial Gdr 122. Name and Address of Fac		Fallston, Maryland neral Home, P.A.
E Per B	1	Mily a my	1317 Cokesbu	iry Road, Abir	ngdon, Maryland 21009
Physician /Medical		23a. Part I. Enter the disease, or conflict ons that caused the death. Do no failure. List only one can e on ach line.	ot enter the mode of dying, such a	as cardiac or respiratory arres	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of Due to (or as a consequence of):	gastric wall per	foration due to	gastriculcer Death
		Sequentially list conditions, b			
ų.	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.			
Do E	Exar	events resulting in death) Last Due to (or as a consequence of):			
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Box 68760, e death certificate be the attending physicic of for use as the buried for us		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
x 68	cian	past 12 months?	Fetal death 3 Ecto Other (Specify)	opic pregnancy	Month Day Year
BO he death the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	百	Part II. Other significant conditions contributing to death but not resulting Pyelonephritis	g in the underlying cause given in		acco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
ords, w require is been signature should b	eted	Tyclonephileis		24a. Was an	24b. Were autopsy findings available
ecol he law ate has age 2 st	ompleted			autopsy perform 1 ✓ Yes 2	ed? death?
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f Vit	2	1 ✓ Yes 2 No Rospital 1 ✓ Inpatient 2 ER/O	utpatient 3 DOA Other,4 Time of Injury 28c. Injury at W		
on of anding Ph tth. r: After t	Ë	27. Manner of Death 1 Natural 5 Pending Pending 28a. Date of Injury (Month, Day, Year)	Time of Injury 28c. Injury at W		w injury occurred
Division tal or Attendi rs after death. al Director: A	ertification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building		eet and Number or Rural Route Number, City
Dj spital hours a neral l	8	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the hest of my knowledge dec		or Town, Sta	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On the basis of examination and/or i			
To with Cour	Mec	29b. Signature and title of certifier	29c. License numb	per	29d. Date signed (Month, Day, Year)
		Colyn MA	O.C.M.E.		June 30, 2011
0		30. Name and address of person who completed cause of death (Ilem 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 90	0 W Baltimore Street Br	altimore MD 21223	
` S	ate			aminore, IVID 21223	
Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.1		

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Baran 135 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FAANKLIN SQUARE Baltimore HOSPITa Roseda 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days Hours Min. 86 Mar vland 218-18-8105 **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygene. and mental Hygene. and mental Hygene. ananked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21237-4508 4 Banat Court U.S.A. zabeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes. Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\,\text{th} \end{array}$ College (1-4 or 5+) Clothing Store Cosmetic Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) ည Bertha Cituk Antonio permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina M. Morini/Daughter | 4 Banat Court Rosedale, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Jul Wate 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother Policin DME n C Holly Hill Mem. 9, 2011 Middle River, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facili Kaczorowski Funeral Home, P.A 1201 Dundalk Avenue Baltimore, Md.23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORDNARY ANTELY ALGERE SIP BYPASS IN 2000 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions. in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or): ATRIAL PERRICLATION 4 YR Exami CHRONEC Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYLODYS PLAS YIC 5 YNDROME 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 Inpatient 2 FR/Outpatient 3 IDOA s after death.

Director: After this d in by the funeral d 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZODE, ZERD ST. , BALT, MD. ZIZIB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

11-04803 Jesse Bealey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Medical Examiner 0803 hrs JESSIE ALEXANDER BAILEY, JR. June 28, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16 South Patterson Park Avenue Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Hours Director 1 X M 2 F CMARYLAND 218-42-2436 67 10/27/1943 Usual Residence of Decedent 10a. State 10b. County ij 10c City Town or Location 10d Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Y Yes 2 No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 S. PATTERSON PARK AVE 21231 U.S.A Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 X No 1 Yes Pages i and 2 should be filed within 72 hours after 3 Widowed 4 Divorced if Yes, Give Yeer 1 Yes 2 X No specify: WHITE Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 LABORER **NEWS AMERICAN** and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) **JESSIE** ALEXANDER BAILEY, SR. Be **EMMA** VIOLA LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD WILLIAM BAILEY BROTHER CLINTON STREET, BALTIMORE, MD 21224 704 S. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) BAYVIEW CREMATORY 7/1/11 Donation 5 Other Specify BALTIMORE, MARYLAND 22. Name and Address of Facility
LILLY & ZEILER
700 S. CONKLING 21. Signature of Euro λ L S 21224 23a. Part I. Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and Martine Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical #1 amended as Noted Per Me G917 7/08/2011 JH physician the burial -UNPENDED X AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ bably 4 🗹 Unknown Completed topsy findings available completion of cause of

The law requires that the death certificate be executed Records, P.O. certificate has Be Division of Vital After this Certification: To Lirector d in by the f deat 1. filled in by hours a er

Prostate Cancer	1 Yes 2 No 3 Prot
	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes
25. Was case referred to medical	26 Place of Death (Check only one)

					1 ✓ Yes 2 No	1 🗸 Yes	2 No
25. Was case referred to medical	V		26.Place	of Death (Check	only one)		
examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursir	ng Home 5 Residence	6 Other: Scer	ne
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Inju	ry at Work?	28d. Describe how injury of	occurred	
1 Natural 5 Pending	(Month, Day, Year)		1 ,	res 2 No			
2 Accident Investigation							
3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, street, factor	y, office b	uilding, etc.	28f. Location (Street and I	Number or Rural Ro	oute Number, City
4 Homicide determined	(Specify)				or Town, State)		

(Check only 1 Certifying Physician: To the best of my knowledge, death occurred a		
one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	in my opinion, death occurred at the time, date e	and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) 201 Registrar

32. Registrar's Signature Jack

To the Funeral

Medical

June 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 2137 PM 201 Thomas T. Banks 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICAMIA If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F (Month, Day, Months Days Min Maryland 1934 Director 217-36-1397 76 Aug Usual Residence of Decedent shov 10a. State 10c. City, Town or Location ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 😾 No Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O. Box 158 Stockyard Road 21826 USA · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2X Married 2 Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 155-57 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the 12 self employed of Health and Mental Hygie If item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Harry Banks Mildred Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, P.O. Box 158 Stockyard Road Fruitland, MD Department of Health ar Important: If item 27 is any injury or other trau Barbara Banks/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Sign ture of Funeral Service, ice is 19 State Anatomy Board 655 W. Baltimore Street MD Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or seart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ disease or condition Medical resulting in death) **Examiner** Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine (or as a consequence of) 001 and burial-trar that initiated events Due to (or as a consequence of resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physicia eted filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. May er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 2 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AM 201 10:36 Byrnes une Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Cente Baltimore 8 Date of Birth (Month, Day, Apr 30, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Hours Min. Director 212-12-7928 1925 Maryland 86 Usual Residence of Decedent show or 28a-f shoven and an art 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 √ No MD Queen Annes Grasonville 10e. Street and Numbe 10f. Zip Code ŏ 10g. Citizen of What Country? : If item 27 is marked other than "natural", or items 23a o or other traumatic event, the Medical Examiner must be Funeral 108 Fox Run 21638 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) salesperson medical equip/supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leo A. Byrnes Elizabeth Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Byrnes/son Health a 108 Fox Run Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) permit. Sign to re of Emery Service Konald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, ΜĎ 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause Final Physician/ disease or con resulting in death) -ardiamyorath Medical Due to (or as a consequenc # of): Examiner Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending newsimis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation Records, 1 Yes 2 No 3 Probably 4 Unknown Prostate 24b. Were autopsy findings available 24a. Was an cate has page 2 s autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No Hospital: ုင 1 Yes 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Division of Vital completed filled in by the funeral director,

> State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and title of certifi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Phelan

31. Date filed (Month, Day, Year)

JUL 0 7 2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

une

Baltimore

2011

29c. License number

Greene St.

D7252

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2Day Month June 2011 10:00 AM Florence Mae Bindeman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford 1404 Amber Square Belcamp 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthdav 1 ☐ M 2 🗓 F 214-22-4999 93 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Harford Bel Camp 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 1301 Sandwort Ct; #103 21017 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Specify: white 3√ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Clara Kalbfleisch Louis Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1301 Sandwort Ct #103; Bel Camp, Maryland 21017 Emma Carr - daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) S. Wede, 22. Name and Address of Facility State Anatomy Board 21. Signa are of runeral Service Ronal a Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final END disease or condition resulting in death) STAGE -UNG ZAY Due to (or as a consequence of): OROHARY Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery - NA -3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobaccouse contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OF SMOKING 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □ Yes 30 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) HOSPICE

Physician /Medical Examiner

> and burial-trar

attending physician for use as the burial

is certificate has been signed by the director, page 2 should be detached

After this

within 24 hours after death

To the Funeral Director:
completely filled in by the

death.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

೭

Examine

Physician/Medical

2

Completed

Be

Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, it is Medical Evan in a by notified at once.

Baltimore, Maryland 21215-0036

Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1∐ Yes 2 🗌 N 27. Manny of Death

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

Matural Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

00060532

WALNUT LANE

6-28-201

ABELDEEN MP

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day ZOAM 6: Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ouns Hopkins ane utimore Social Security Number 8. Date of Birth (Month, Day, 6. Sex **Funeral** Age (In yrs. last birthday) If Under If Under 24 Hrs Birthplace (State or Foreign Country) 1 🗆 M 2 🖈 F Months Hours 215-60-2221 56 Director 09/11/1954 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other transfer. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2708 West Woodwell Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 🔀 No Specify: White 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Kuhn Frederick Mary Frances Pullen 19a. Informant's Name/Relationship (Type, Print)
James Brown / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code, 2708~ West Woodwell Road, Baltimore, MD 21221 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey crem. 1 Burial 2 X Cremation 3 Removal from State 7/2/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota 22. Name and Address of Facility
Maryland
POBOX 141 Marshall Cremation Services 3, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death GINCON Physician/ DN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner on a Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death signed by the a d be detached f 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes No. 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, eral Director; After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date sign Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BECKER ARLYN Physician/ Month 2011 83 12:20 A M Medical 4a. Facility Name (if not institution, give street and number **Examiner** City, Town, or Location of Death 4c. County of Death
BALTIMORE MILFORD MANOR NURSING HOME PIKESVILLE 5. Social Security Numbe 214-22-1812 last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Min. Months Davs Hours 10/15/1926 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County BALTIMORE 10c. City, Town or Location 10d. Inside City Limits the Maryland be notified at Director PIKESVILLE 1 Yes 2 X No o 10e. Street and Number 10f. Zip Code 21208 10g. Citizen of What Country? USA permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be once. Funeral 4204 OLD MILFORD MILL ROAD #303 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) SYLVIA 17. Father's Name (First, Middle, Last) FOX BANK ည **GEORGE** 19a. Informant's Name/Relationship (*Type, Print*) ALBERT BECKER/HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 MILFORD MILL ROAD #303, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗔 Other (Specify) ANSHE EMUNAH CHAIM BALTIMORE, MD 07/06/2011 21. Signature of Funeral Service Licens LEVINS ROAD, Name and Address of Facility SOL 8900 REISTERSTOWN MD 21208 PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ear Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Other (specify) Month Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign d be cate has been sig , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Ye JUL 0 7

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32. Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Τ. Angela Chandis 6Day July 2011 4:52 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice of Columbia Howard Columbia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) China Nov. 1922 Months 1 M 2 X F Hours 117-30-9340 88 Director Usual Residence of Decedent shov 10b County the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified Maryland Howard Columbia 1 ☐ Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral death with 12290 Green Meadow Drive 21044 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black White etc by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Chinese 3 ₩ Widowed 4 □ Divorced Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Robert Chandis / Son 21 Mountainside Dr., Mendham, New Jersey 07945 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Metro Crematory Inc. | 07/06/2011 | Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death

YNFHOWN Immediate Cause (Final ENCEPHALOPATH HEPATIC < Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown ed by the a 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after deat Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title

Registrar

DHMH 17 Rev 7/2009

State

ne Columbia

me and address of person who completed cause of death (Item 23a) (Type, Print)

CALAV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 14:30 Keith P. Cox 0 201 Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 3/6/62 9. Birthplace (State or Foreign Country)MD **Funeral** 1 XM 2 - F Hours Min. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore Yes 2 No 10f. Zip Code 21222 10e, Street and Number 10g. Citizen of What Country? Funeral 520 Chateau Ave USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. African and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 Married 2 **X**No Maryland 21215-0036 1 Yes 1 ☐ Yes Ž☐ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4X Divorced Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)

Laborer Roofer Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname)
Alice Jean Pender 17. Father's Name (First, Middle, Last) ပ Frank W. Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Jean Pender/Mother 520 Dhateau Ave, Balt., MD 21212 Department of Health Important: If item 27 injury or other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Balt., MD 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 De cemetery, crematory or other place) al from State 4 Donation 5 Other (Specify) Bayview Crem. 22. Name and Address of Facility Harilt., Close 2665510BA uneral Service 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani Bilateral preumonia Medical resulting in death) Due to (or as a consequence of): distress syndrome Examiner ute respirator Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine vorus infection Cause (Disease or linjury Humanimmono de burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 19 9 Unknown detached signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has by page 2 s performed After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shama 000 RES 7/3/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abhishek Sharma 5601 Loch Raven Blud 21239 Abhishek Shanma 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tin Shue Chin ul Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE CENTER ANNE BALTIMORE WASHINGTON MEDICA If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours China September 25, 1929 81 Yrs Director 579-40-2385 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1 Yes 2 No **Maryland** Anne Arundel **Odenton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 Funeral 2450 Apple Blossom Lane, #103 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No 1951If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Asian Completed 3 Divorced 1956 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Senior Collection Specialist Library of Congress 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wee Kok Chin Suet Jing Kwan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2450 Apple Blossom Lane, #103, Odenton, MD 21113 Marie Chin/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State July 8, 4 Donation 5 Other (Specify) Resurrection Cemetery Clinton, Maryland 2011 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 21. Signatura J Fun Service Liornsee M01386 edisease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final Physician/ METASTATIO disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine DIOVULMONA that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completion of cause of death? Yes 2 2 No this certificate 1 Yes **Division of Vital** 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manny of Death 28b. Time of 28c. Injury at work? Certificate: 28d, Describe how injury occurred After 5 Pending Natural work? 1 ☐ Yes ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2 o completed cause of death (Item 23a) (Type, Print) Glen Burnic

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	m.X.	٠.	8202 Rambli:	ng Rose Lane			Lau	rel		Ar	nne Arur	ndel
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	place (State or Foreign try)
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	death item ner n		11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14	 Race - Americ Black, White, 	
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Maryland 21215-0036	2 sho Ith an 27 is trau		Claudio Flag			6. Maiii 8202	,	ng Rose]		•		
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Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service	Licensee		22	2. Name and Addres		Donaldso			ome, P.A.
<u>m</u>	8 2 5 6 8		anne	X1/XXX	M01103		313 Talbot			cel, N	4D 2070	07
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Ğ.	v requires that the death certifics been signed by the attending p should be detached for use as t	Physician/Me	1 ☐ Yes 2 🗗 No g ☐ Unknown	g 🗆 Unknown		0 2						
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Division of Vital Records,	al or safte		4 - Hornicide deter	building, ef	tc. (Specify)				City or To	wn, State)		
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Charle 2 Modical	ng Physician: To the best of Examiner: On the basis of	evernination and	or invos	tigation in my oninic	n death occurred	at the time date	and place a	and due to the ca	ause(s) and manner stated.
	To the Pwithin 24	₩	only one) 3 Certifyir	Nurse Practioner: To the	e best of my kno	wledge,	death occurred at the	e time, date and pla	ace, and due to t	he cause(s)	and manner as s	Day Year)
	5.≱58		29b. Signature and title of certifi	welly	(Che	1	D 5	5403-		7/	05/11	-a, 100/
) \ \ \ \ \		30 Name and address of person	n,who completed cause of	death (Item 23a)	د ا <i>داد</i> ؛ ا .Type)	Print)	/	- A11	OHAF	PARILA	102-0917
	/		only one) 3 Certifying 29b. Signature and title of certification of the signature and address of person 200 Certifying August 200 Certifying	KHETAN,	7610	CAT	eroll Av	E#160	,1 17 00	DECAIN	717	112
	Sta											
	Registr	ar	JUL 0 7 2011	Jewis B	. par							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JYMb 3 day 20 1ª1 16:00 ROBERT WARREN CHANEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 204 10th Street Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 XX 2 - F Days Hours Min Months Junte Day, Year 1941 70 Director 213-76-9117 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 10th Street 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒☒o If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 X Kever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", White Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natu
any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grade 5 disabled disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Howard Lee Chaney Martha Serena Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Love Thornton 9106 Windemere Way cousin Jessup, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Meadowrdige Mem Pk 7/6/2011 Dorsey, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 3 Years complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure, List nly one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of) Examiner Diabetes 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed HTN 5 years Due to (or as a consequence of): Physician/Medical 68760 phys the b IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ρ in the past 12 months? Dav 1 Yes 2 No ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascular Insufficency 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Ves 2 XXo 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2XXNo ဂ္ဂ 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XXatural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box (P.O. Records, To the Hospital or Attending Physician: The lwithin 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page of Vital Division

State Registrar

Medical

29a. Certifier (Check

only one 29b. Signatur

30. Name and address of pe

John Margolis,

eted cause of death (Item 23a) (Type, Print)

32. Registra 's Sign

Certifying Nurse Practioner: To the best of my ko

M.D.

123 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause

13952 Baltimore Avenue Laurel, Maryland

29c. License number

D25430

🕊 or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

July 1, 2011

20708

wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 3, Phyllis Cromwell Cowan 2011 11:50 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 6, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 218-28-4419 80 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Wadical Examiner must be not fled at 1 ☐ Yes 2 ☐ No Director MD Baltimore Parkville 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 8800 Walther Blvd, Unit 1602 21234 U.S.A. 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. White 2 Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Teacher/Principal Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Custer Cromwell LeCompte George Lula မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra Frederick F. Cowan, Jr.-husband 8800 Walther Blvd, Unit 1602, Parkville, MD 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 7/5/11 Towson, MD 4 ☐ Donation 5 ☐ Other (Spegify) 21. Signature of Funeral Servi Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) End Stage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown Ö 9 Unknown signed by to be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation To the Hospital or Attenums within 24 hours after death.

To the Funeral Director: Aft 1 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

JUL 0 7 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8300

32. Registrar's Signature

058646

7-14

Baku: (10 MD 2,234

11-04923 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elmer Benjamin Collier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Day Month D July 1, 2011 Elmer Benjamin Collier Medical Examiner 1837 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3001 South Hanover Street **Baltimore** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Months Davs Hours Director 219-10-4404 94 Sept 26, 1916 1 M 2 F country Virginia Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5508 Park Road 21225 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married Yes Yes No White 4 Divorced Yes 2 X No specify: Specify: ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tank Tester Buffalo Tank Co. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Collier Bertha Dean epartment of Health and Menportant: If item 27 is ma jury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Muir daughter 6 Fast Randall Street Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory July 5, 2011 Baltimore, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 East Fort Avenue Baltimore, Maryland 21230 ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset end /Medical Death a. Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last law requires that the death certificate be executed physician and the burial - transi Physician/Medical UNPENDED **AMENDED** of Vital Records, P.O. Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy detached for use as Fetal death Month 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been si, page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) 8 examiner? Hospital: 1 Inpatient Other Mursing Home 5 Residence 6 🗸 Other: Scene DOA ER/Outpatient 3 1 Yes 28a. Date of Injury Jul 1, 2011 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred Certification Subject jumped from bridge 1 Natural Division 1 Yes 2 ✓ No Pending 2 ___ Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 2600 South Hanover Street, Baltimore, Md. determined (Specify) River 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 2, 2011 O.C.M.E.

DHMH 17 Rev 1/2001

State Registrar 900 W. Baltimore Street, Baltimore, MD 21223

person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Manuel Chavez uan 28 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 🗓 M 2 🗆 F Peru 86 Aug 3, 220-44-3290 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 23a or 28a-f show ist be notified at ☐ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number must be 21204 USA 306 Alabama Road Funeral 14. Race - American Indian, Black, White, etc. ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White <u>Ş</u> 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) mechanic various 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mentai Isabel Ebert Health and Menta em 27 is marked Juan Manuel Chavez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1736 Glen Ridge Road Baltimore, MD 21234 Julia Chavez/daughter other 1 If item or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit, Page Department o Important: If any Injury or 5 Other (Specify) 4 🔀 Donation 21. Signature of Funeral Service Liceusee
Ronald S Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Dargetor Baltimore, MD 21201 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Standing **Physician** disease or condition resulting in death) 009 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the ! as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? has 2 No 1 ☐ Yes 2 X No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 \square Nursing Hame 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 KER/Outpatient 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Injury 1 X Natural Hospital or Attending s after dea. rai Director: After 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10028684 June 28, 2011

State Registrar 31. Date filed (Mon

DHMH 17 Rev 1/2001 11595 32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			or Print in Black In			•			
		1 - For State Registrar	ate of Maryland / Depa Cer	artment of Health an rtificate of Death	Reg.	/ 11 1 1 6 1 4 6 0			
Physic /Med		1. Decedent's Name (First, Middle, Last) REGINA	COLLINS		06 2	Day Year G.45PM			
Exami Funeral Director	#8	4a. Facility Name (If not institution, give street Blue Point Nursi 5. Social Security Number 217-74-9638 1	ng Home 7. Age (In yrs. last birthday)	Hrs. 8. Date of Birth Min. 08/27/1	4c. County of Death 9. Birthplace (State or Foreign Country) MD				
Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Lo		timore	10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
th with the 23a or 28a ist be notified	al Director	10e. Street and Number 301 Chesapeak	e Avenue	10f. Zip Code 21225	10g.	Citizen of What Country?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any once.	by Funeral	1 Never Married 2 Married 1	TYes 2 TxNo	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I 1 ☐ Yes 2 No Specify:	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
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nd 2 should be filed within 72 hours affulls and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exami	To Be Co	12 17. Father's Name (<i>First, Middle, Last</i>) Michael Colli	<u> </u>	Secretary Legal 18. Mother's Name (First, Middle, Maiden Surname) Angelina Leoni					
ss 1 and 2 shou of Health and M Item 27 Is mar other traumat	-	19a. Informant's Name/Relationship (<i>Type. Pi</i> Angela Bray / Dau	ghter 100	McVey Drive,	Centervil	le, GA 31028			
Dermit. Pages 1 are Department of Hee Important: If Item any Injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ▼	Final Jo	ourney Crem. 7/	/8/2011 ₩oc	. Location - City or Town, State			
Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition resulting in death)	as that caused the death. Do not entuse on each line. Auto Immune Due to (or as a consequence of):		<u>3, Baltimo</u>	Services re, MD 21203 Approximate Interval Between Onset and Death			
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	Due to (or as a consequence of): Pure type Due to (or as a consequence of): yes, outcome pf pregnancy	Ìg.					
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	ıysician,	in the past 12 months?	Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>		23d. Date of delivery Month Day Year			
w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contribut	ing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death? 2□ No 3□ Probably 4 ☑onknown			
The law recate has being	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1			
Physician: this certificaral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospit	1 Inpatient 2 ER/Outpatier	nt 3 DOA Other: 4 Nurs	f Death <i>(Check only one)</i> ing Home 5 ☐ Residence	e 6 □Other (Specify)			
ttending death. ctor: After / the fune	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	a. Date of Injury (Month, Day Year) e. Place of injury - At home, farm, str building, etc. (Specify)	Work? M		t and Number or Rural Route Number,			
To the Hospital or A within 24 hours after To the Funeral Direction Dispersion of the Funeral Direction of the Funeral Di	Medical C	(Check only 2 Medical Examiner: 0	i: To the best of my knowledge, deat On the basis of examination and/or in nd manner stated.	th occurred at the time, date and estigation, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)			
To the within To the comp	M	29b. Signature and title of certifier	MP	29c. License number D 31 44		Date signed (Month, Day, Year)			
		30. Name and address of person who comple SHOA(IZ A . HASH	MI MD, 821 4	V. EUTAW ST	Suite 308	BALTIMORE MDZI			
S	tate	31. Date filed (Month, Day, Year)	32. Degistrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM Raleigh Coleman 07 Christopher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death n/a Baltimore Baltimore Medica Center Social Security Number . Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Min. 1/07/295/ T954 $V_A^{Country)}$ **Director** 56 228-82-2257 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 USA 5214 Mayview Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Divorced Year or Dates. 1974-77 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Crane Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ernest Coleman Jr. Margaret Ann Mitchell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Starr Coleman-Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 5214 Mayview Ave Baltimore, MD 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7.7.2011 | Hanover, MD Ardent Crematory Sign ture Funeral Sa ^{22. Name and Address of Facility}
John L. Williams Funeral Directors P.A.
4517 Park Hgts Ave Baltimore, MD 21215 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Spontaneous Peritonita Bacterial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide the Hospital Medical 29a, Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 992094189 Baku 00 2011 Uttera

State Registrar

DHMH 17 Rev 7/2009

MD

32. Recistrar's Signature

Greene Street

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baker

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible [] | State of Maryland / Department of Health and Mental Hygiene

Lagene Caner	1- For State Registrar Certificate of Wallyland / Department of Certificate of Registrar	f Death	Reg. No.						
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	St. Joseph's Hospital	4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore County						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 2 1 4 - 1 4 - 7 0 7 3 1 M 2 F 66 Yr		Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign CountryMARYLAN)						
nd show any icc.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca MD BALTIMORE		10d. Inside City Limits 1 \(\overline{\text{Y}} \) Yes 2 \(\overline{\text{No}} \) No						
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timore, MD 2: 1. Pages 1 and 2 should Iment of Health and M reart: Witem 27 is m. ro other traumatic or	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other states.	sition (Name of cemetery, Date ther place)	20c. Location - City or Town, State						
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the	2	AE CREM. 7/5/11 Name and Address of Facility CAPITOL 125 MARYLAND AVE., 1	MORTUARY						
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To the Ho within 24 To the Fr completel	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	30. Name and adoress of person who completed cause of death (Item 23a)	O.C.M.E.	June 26, 2011						
P.	Pamela E. Southall, MD Assistant Medical Examiner 90	0 W. Baltimore Street, Baltimore, MD	21223						
State Registra		all							

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	• Examin	er	4a. Facility Name (if not institution Stella Mar:	street and number)				, Town, or noniu		of Death			c.County of Baltin			
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6, 2011 Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٦	Walter LaBar: 19a. Informant's Name/Relation		Cons. Deleat	<u></u>	T			Ire		ossman				
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Bal	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1								204	04 1050 York Rd				
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ox 6	ath ce attend for us	ician,	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 - Feta	Ideath 3	Ectopic Other (s		у			201	23d. Date		y Year
). B	law requires that the death certificate be nas been signed by the attending physic e 2 should be detached for use as the bu	Medical Certificate: To Be Completed by Physician/Medical	9 Unknown'		9 Unknown											
	es that signed I be de		Part II. Other significant condi	tions co	ontributing to death b	ut not resu	ulting in the u	ınderlying	cause give	en in Part	l.			_		ause of death?
DELLOSSO Vital Records,	/ requii been shoulc											24a, Was		24b. We	re autopsv	findings available
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DE tal	cian: T ertifica ector, p		25. Was case referred to medica examiner?	-	Hospital:						ath (Check		21	101	163 2	
f Vi	Physi r this c rral dire		1 Yes 2 No 27. Manner of Death		1								Specify)			
ELVA	Attending Physician: The sr death. ector: After this certificate I by the funeral director, pagg		1 Natural 5 Penc 2 Accident Inves	r, Year)												
ELVA Division of	or Atter after de Directo in by th		3 Suicide 6 Could not be								nd Number or Rural Route Number, e)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier													
	To the Ho within 24 To the Fu completed		(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manor as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	To To COI		29b. Signature and title of certifi	er	110	Q_{\bullet}	+A	129	c. License	number	7016		29d. Da	ate signed (/	Nonth, Pay,	2011
	10 de		30. Name and address of person	who o	completed cause of de	eath (Item	23a) (Type, F	Print)			1			019	U	2011
	,		ERNESTINE WI		•	who Cid	2300	DULAN	IEY V.	ALLE	Y ROA	D	TIMO	NIUM	MD	21093
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11-04986 Todd Timothy Dill		Please Type or F	Maryland / Depa		ealth and			egible.	201	21433
Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Lest)	N: 1/a	TIT	Ja lli		2. Date of De	Reg. No. eath Day	Year	3. Time of Death
Medical Examin	ier	4a. Facility Name (if not institution, give stre	ed and number)	14b. 0	ity. Town, or I	ocation of Deat	July 4, 2	011	ounty of Death	0820 hrs
		Johns Hopkins Hospital			altimore				outry of Bout	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	N	Under 1 Year lonths Days	-	_	Birth (MM/DE	Foreign	A AA
		Usual Residence of Decedent	2F	Yrs.			0912	1 /20	77 000	intry) 🖁 D
nd ibow any see.	١	10a, State 10b, County		Town or Location Himbre						10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number	/ <1 · L	10	f. Zip Code	n h		10g. Citize	n of What Coun	try?
with the ns 23a c			Was Decedent Ever in U.S			panic Origin? (S		lo- 14	. Race - Americ	an Indian, Black,
er death	Funeral	1 Never Married 2 Married 1	Armed Forces? Yes 2 No		₩.	Mexican, Puerto	o Rican, etc.)		White, etc.	الم م
2 hours afte "natural", Examiner	ē ē	Widowed 4 Divorced If Ye or Divorced If Ye	ates:	16a. Decedent's U	sual Occupati				d of Business/Ir	dustry
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21215-0036 uld be filed within 7 Mental Hygiene Hygiene cevent, the Medica	် င်	17. Father's Name (First, Middle, Last)	IT			8.Mother's Nam	e (First, Middle	, Maiden Su	ırname)	
2121; Duld be fil. Mental H marked ic event, t	To Be	19a, Informant's Name/Relation hip (Type,	Print)	19b. Mailing Add	dress (Street	and Number or	Rural Route N	mber, Çity	or Town, State,	Zip Code)
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I sant: If item 27 is marked or other fraumatic event,	77.1	Ebony Jones Tran 20a. Method of Disposition	amother	1505 Fallace of Disposition	plar G	rove St	reet of	saHi r	100e, Ma	. 21223
MOFE, Pages I a nent of He int: If ite		1 Burial 2 Cremation 3 F		rematory or other p		letery,	Date	20c. Lo	cation - City or	own, State
Baltimore permit. Pages 1 a Department of Fit Important: If in injury or other t	ł	4 Donation 5 Other Specify: 2 Signature of Funers Service Licensee	N. IV	101011	and Address	of Facility	51		HIMOre	NHI FILE
Physician	4	23a. Par I. Enter the dr ease, or complication	ons that caused the death.	Yaua Do not enter the	hn C. G	Teene f.	or respiratory a	rrest, shock	e Mary	Approximate Interval
/Medical	1	failure. List only one cause on each tir	_{e.} N(Sudden Une							Between Onset and Death
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and timeral director, page 2 should be detached for use as the burial - transmission and the state of the st	<u>g</u>	X UNPENDED AN	ENDED 23a, 27, 28	8a-f,per	me,g91	9 9-23-	11 sm			
3760 ficate b g physi	/We	23b. Was decedent pregnant in the	c. If yes, outcome of pregn		» [Tertonio arono	-110.		Date of delivery	
Box 68760 e death certificate be the attending physi ed for use as the bu	Physician/Medica	past 12 months?	Pregnant at time of dea	2 Fetal de ath 5 Other	eath 3 [Specify)	Ectopic pregn	ancy	M	onth D	ay Year
D. B. true de by the sached for		Part II. Other significant conditions conf	The second secon	- sulting in the under	lying cause gi	ven in Part I.	23e. Did	tobacco us	e contribute to t	ne cause of death?
S, P.O. uires that the nisgned by d be detack	g g						1 □ Y	es 2 🗸 N	lo 3 Proba	ably 4 Unknown
Cord law req has bee	Completed		<u></u>				24a. Wa auto			opsy findings available empletion of cause of
I Re II. The or, page		25. Was case referred to medical		<u>-</u>	26.Place	of Death (Check	1 🗸 Yes	2 No	1 Yes	2 No
Vita bysicia this cer	o Be	examiner? 1 ✓ Yes 2 No	al: 1	ER/Outpatient 3		Whom —		Residenc	e 6 Otiner:	
		1 Natural 5 5	(Month, Day,Year)	28b. Time of Injury fd 7:00 a		at Work? es 2 🔀 No	28d. Describe Unknow		осситед	-
Division of Vital Records, pital or Attending Physician: The law require ours after death. Ieral Director: After this certificate has been similal in the timeral director, page 2 should be the fine of the fine	Certification:	2 Accident Investigation _	28e. Place of Injury - At hor						Number or Rur	al Route Number, City
Ospital lospital uneral ly filled		4 Homicide determined	(Specify) Reside				Baltim	ore,M	d	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execuvithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transmission.	Medical	one) 2 Medical Examiner: On t	o the best of my knowledg he basis of examination an manner stated.							
	Ĭ	29b. Signature and title of certifier			29c. License O.C.M			i	te signed (Mon.	th, Day, Year)
	-	30. Name and eddr ss of person who comp	eted cause of death (Item 2	23a)	0.0.10	·· - ·	_	July 5	, 2011	
8		Pamela E. Southall, MD As	sistant Medical Exan	niner 900 W.	Baltimore	Street, Balt	imore, MD	21223		
Sta Registra	~	31. Date filed (Month, Day, Year) JUL 0 7 2011	32. Redistrar's Signatur	1	-					
DHMH 17 Rev 1/200 OCME 2006	01	002 0 1 2011	Marine /	ORIGINAL				OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month 08:58 AM 30 Physician/ ANN DORIS 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Columbia Howard County General Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 6. Sex 5. Social Security Number May 16, 1946 Maryland Days Hours **Funeral** 1 M 2 X F Yrs 65 195-36-2885 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 28a-f shov 10a. State must be notified at 1 Yes 2 No Director Catonsville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number should be filed within 72 hours after death with the I **USA** ō 21228 by Funeral 23a 514 Lee Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Black, White, etc 11. Marital Status Armed Forces? white 1 Never Married 2 Married Specify: 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 3 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natur 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) healthcare and Mental Hygiene. nurse 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Grace Mary Ikena ျ Thomas Emerson Frey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 514 Lee Dr; Catonsville, Maryland 21228 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other traus Forest Deal - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 🗖 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Romand Service Licensee de, 21201 655 W. Baltimore St; Baltimore, MD 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final disease or condition resulting in death) Physician/ 5.5 455 Due to (or as a consequence of) Medical EAS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examiner sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ Year Month Day in the past 12 months? Pregnant at time of death 4 Pregnant 1 ☐ Yes 2 ☑ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed by HYPO THY RUIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 A Inpatient 2 ER/Outpatient 3 DOA 2 **X**-No 1 Yes 2 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No **X** Natural Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

30. Name and address of person who complet	MD 5753 CEVIT
31. Date filed (Month, Day, Year)	P. Registrar's Signature

29b. Signature and title of certifier

State Registrar 29c. License number

033768

Coumbia mo 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TUNE DELBROCCO JOSEPHINE 20T1 12:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 📭 Days Hours Min. J*a*m**1**th1^{Day}1^Y9'22 Itanty 89 Director 215-16-1061 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 28a-f 1 Yes 2 No Md. Harford Bel Air 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014-6983 U.S.A. 915 Shephard Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates. ?7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Home Maker Own Home 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Domenica Scilipoti Mario Scilipoti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shephard Court Bel Air, Maryland 21014 Charles M. Catalfamo/son MOS Blace of Disposition (Name of Semetery, crematory or other place)
Holy Redeemer Cem. 20a. Method of Disposition Jul Dynte 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 🗓 Burial 2 □ Cremation 3 □ Removal from State 6, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caczorowski Funeral Home, P.A. 21. Signature of Funeral Service I Sensee 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ of 5 range derven disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. in jury that initiated events Examiner Due to (or as a consequence of) and -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Feral acc in the past 12 months? Month Year Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy death? 1 🗍 Yes 2 🗓 No Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** funeral director, examiner? Hospital Other: ြု 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) David 5 D32255 JUNE 29 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June $2^{\frac{Day}{3}}$ 20°I1 Medical Clover, Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death reater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06,23,20 7. Age (In vrs. last birthday) Funeral Min. 53 1 🗆 M 2 🗷 F Days Hours Director INFANT Usual Residence of Decedent 28a-f shov 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD Perryville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1122 Frenchtown Rd 21093 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Infant Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Collin, Pecora Patricia, Dorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Frenchtown Rd; Perryville, MD 21093 Patricia Dorn - mother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 1n State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Diffector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Leart failure. List only one cause on each line. Immediate Cause (Final Physician/ Nere disease or condition resulting in death) Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, it any, leading to in reclute cause. Enter Underlying Cause (Disease or linjury Que to for as a consequence on Exam The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Tyes 24a Was an autopsy performed? Yes 2 No page Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at the Hospital or Attending I hin 24 hours after death. (Month, Day, Year) 1 Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mar 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9:25

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

má

White

P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ asquale Mont) Kober 7:24 PM thon Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PINTER Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 54 Days 215-60-0490 1**X** M 2 □ F Director MD 08/03/1956 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must have also any injury or other traumatic event, the Medical Examinar must have also any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA by Funeral 21224 3200 Eastern Avenue Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No Black, White, etc. 1XXNever Married 2 Married altimore, Maryland 21215-0036 White If Yes, Give 1 Yes 2 No Specify Year or Dates. Army Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 10 Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Georgia A. Hogg Joseph A. Depasquale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard R. Depasquale, 21221 352 Leeanne Rd., Essex, MD Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 7/7/2011 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Donota Marshall 22. Name and Address of Facility
Maryland
PO Box 141 Cremation Services 413, Baltimore, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line rediate Cause (Final ase or condition Interval Between Onset and Death Immediate Cause (Final at ancer Ph, sician/ 25 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 🖾 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital XOSPICE 2 🖺 No Other: ္ဝ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed causer death (Item 23a) (Type, Aint)

DHMH 17 Rev 7/2009

State Registrar Jeorge

filed (Month, Day, Year)

1 CLCS

32. Registrar's Signature

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2011

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ivision of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2011 6:40 P ^M Mildred L. Erek Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2101 Cedar Circle Drive Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** NOV 21 1 🕱M 2 🗆 Months Hours Min. Country) Year 916 Director 94 WV 220-10-9294 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the all the state of the 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2101 Cedar Circle Drive 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) unknown Personnel Staffing Specialist Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles W. Huff Beulah Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita L. Ledford/Daughter 436 Grovethorn Rd Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Gard. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 7/12/11 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Gel Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month funeral director, page 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2X No 2 🗌 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending work М 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) within 24 hours a Medical 1 🕱 Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examines On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Geriffying Nurs. Practionen To the best of my knowledge, death province at the time date and place, and due to the reventile and manner as status 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 6, 2011

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

			For State Registrar	Please	State of M		id / Dep		Health and			9011	21440
	Physicia Media		1. Decedent's Name	e (First, Middle, La	st) ESHLEN	1AN				2. Date of De Month JULY		ay 2011	3. Time of Death 7:20 a ^M
0	Examir		4a. Facility Name (if STELLA	f not institution, give MARIS	e street and number) HOSPICE	Ξ		4b. City, Town, c	or Location of Death	1	40	c. County of Death BALTIM	
	Funeral Director		5. Social Security Number 236 32 5710 6. Sex 93 Yrs. 7. Age (In yrs. last birthday) 93 Yrs. 91 Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Mopth, Day, Year) 05/31/1918 9. Birthplace (State or Foreign World Worl									ntry)	
	yland -f show ed at	ctor	Usual Residence of 10a. State	10b. County			y, Town or Lo						10d. Inside City Limits
Š.	the Mar a or 28a be notifi	Funeral Director	MD 10e. Street and Nur			R	OSEDA	10f. Zip Code			10g. C	itizen of What Cou	1 🗆 Yes 2 🔀 No
d	ems 23 r must	uner	10 AVEI	RY COUR	12. Was Decedent 8	Ever in U.S	S. 13.	Was Decedent of H	1237 Hispanic Origin? (Sp	pecify Yes or No-	.	USA 14. Race - Ameri	can Indian.
3036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by		ried 2 Married 4 Divorced	Armed Forces? 1 Yes 2 Nes 2 Nes 2 Yes, Give Year or Dates.			If Yes, specify Cuba 1 ☐ Yes 2 🏿 No	an, Mexican, Puert	o Rićan, etc.)		Black, White,	
7.5-0036	n 72 hou e. an "nat Medica	Completed		15. Decedent's E	rade completed)	5±1	(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wor	king	16b. l	Kind of Business Ir	ndustry
21	ed within Hygiene other the ont, the	Be Co	Elementary/Sec 1 2 17. Father's Name (College (1-4 or 5 5 +		TEAC	HER	10 Mathaula Nor	- /Fivet & Aidalle			E COUNTY
1 20 Maryland	ld be file Mental F arked of atic ever	욘	ADDISON		ORE				18. Mother's Name (First, Middle, Maiden Surname) BLANCHE MILLER				
Mar	d 2 shou alth and n 27 is m er traum		19a. Informant's Na CHARLOTT		Type, Print) DAUGHTEF	₹	1		and Number or Ru				
Tore,	age 1 an ent of He t: If item / or othe			☐ Cremation 3 ☐	Removal from State	1 0	Place of Dispo	osition (Name of matory or other place OF FAI	cel	Date 06/11	20c. L	ocation - City or T	own, State
JW 14 Baltimore	permit. Pa Departme Importan any injur			5 Other (Speci neral Service Licen	-		22	2. Name and Addre	ess of Facility CV	ACH/RO	SED	ALE FUN	ERAL HOME
	O	Н	23a. Part 1. Enter t	the disease, or com	plications that caused	d the deat			ESACO A			ORE, MD	Approximate
	Physician/ Medical Examiner		Immediate Cause (disease or condition resulting in death)	(Final	a. Due to (or as	-Dr		ANCE	r				Interval Between Onset and Death
		iner	Sequentially list co if any, leading to in	nmediate	b. Due to (or as	a consequ	uence of):						
	certificate be executed nding physician and use as the burial-transit	cal Examiner	Cause (Disease or that initiated events resulting in death) I	s i	C. Due to (or as	a consequ	uence of):						
3760	ificate be g physic as the bi	Medic	IE EENALE		d								
SHLEMAN BOX 68760	ne death certificate by the attending physic ched for use as the b	Physician/Medio	IF FEMALE: 23b. Was decedent in the past 10 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	Ectopic pregnand Other (specify)	су			23d. Date of delive Month	very Day Year
£. P.0	the Hospital or Attending Physician: The law requires that the death hin 24 hours after death. The Fueral Director. After this certificate has been signed by the attempted filled in by the funeral director, page 2 should be detached for mpleted filled in by the funeral director, page 2 should be detached for	۾	Part II. Other signif	ficant conditions o	contributing to death b	ut not res	ulting in the u	ınderlying cause gi	ven in Part I.				the cause of death?
Z Scord	law requ has beer je 2 shou	Completed	16 							24a. Was			opsy findings available ompletion of cause of
Vital Re	ian: The intificate ctor, pag		25. Was case referre	ed to medical				26. P	lace of Death (Chec	1 Tyes		lo 1 Yes	2 🗆 No
<u>₹</u>	y Physic er this ce eral dire	유	1 Yes 2 2 27. Manner of Death	X √o	28a. Date of inju	ry	ER/Outpatier 28b. Time of		4 ☐ Nursing H	ome 5 Resident		6 Other (Specifi	» Hospice
JR L	ttending death. ctor: Afte / the fun	Certificate:	1 Natural 2 Accident 3 D Suicide	5 ☐ Pending Investigatio 6 ☐ Could not b	e 29a Place of Init		injury	M 1 =	Yes 2 No				
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s		4 U Homicide	determined	building, etc	. (Specify	·)			City or Tov	vn, State	<u> </u>	
	the Hosp nin 24 ho the Fune npleted f	Medical	(Check 2 only one) 3	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	n and/or inves	tigation, in my opini	on, death occurred	at the time, date a	and place	e, and due to the ca	ause(s) and manner stated.
	vitl Co		29b. Signature and	the of certifier	SCANP	,		29c. Licens	e number 4979	2	29d. Da	ate signed (Month,	Day, Year)
n /			30. Name and addre	ess of person who	completed cause of d	eath (Item	23a) (Type (Print)	2. 1/2/1	a. Pa	— <i>H</i>		n. MD2109
113	Stat Registra	_	31. Date filed (Monti	h, Day, Year)	2. Registra	ar's Signa	ure Ser	MAN GAN	W YOUT	my rec	111	NUDION	V 11172103

State Registrar

DHMH 17 Rev 1/2001

Name and address of person

A

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JUL 0 7 2011

31. Date filed (Month, Day,

Merrimac

238

Prince Fred Mi

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Mi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 4^{Day} 201^Y1^a Dedric Keith July 1:30P.M Every Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 306 Hornel Street Baltimore City 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Months \$*e*pt2⁰,1⁹50 213-66-5895 60 Maryland **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irector 1 X Yes 2 No Md. Baltimore City ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Hornel Street 21224-2805 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Handicapped Handicapped Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dedric C. Elinor Every Manuel traumatic 19a. Informant's Name/Relationship (Type, Print)
Steve Manuel / Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4619 Green Cove Circle Baltimore, Md.21219 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jul Nate 20c. Location - City or Town, State Bayview Crematory 1 Burial 2 K Cremation 3 Removal from State 8,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit Kaczorowski Funeral Home, P. A 201 Avenue Baltimore. <u>Dundalk</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ DIUNGA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 100te Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-1 Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' this certificate 2 No 1 Yes Yes 2 sz 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🙀 Residence 6 Nother (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After Natural 5 Pending in 24 hours and control the Funeral Director. Aft work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35761 July 6, 2011

Registrar

State

4940 Eastern Avenue Baltimore,

Md.21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fingerhood, M.D.

Ι.

JUL 0 7 2011

Michael

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2 2011 Andrew George Eilbacher 1:42 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1512 Southview Road Bel Air Harford 9. Birthplace (State or Foreign Country) 1987 Maryland Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🌠 M 2 🗆 F Months Days Hours Min **Director** 214-17-2506 19. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more. 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Maryland Harford Bel Air 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 **USA** 1512 Southview Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White 3 - Widowed 4 - Divorced Specify Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Student College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert George Eilbacher Deborah Lee Bedell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Eilbacher / Mother 1512 Southview Road, Bel Air, Maryland 21015 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Highview Memorial Gdn 7-7-2011 Fallston, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Dantivasci athless 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MONVAS shock, or heart failure. List only one cause on each lir Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown 24a, Was an

25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 😾 Residence 6 🗆 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2

27. Mann of Death 28a. Date of injury (Month, Day, Year) Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be determined

28b. Time of 28c. Injury at 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pragioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3

29d. Date signed (Month, Day, Year)

1550 ORLEANS ST.

cause of death (Item 23a) (Type, Print)

JULY 5, 2011

TOHN'S MOPKINS HOSPITTAL BALTIMORE, MARYLAND

State Registrar

Records,

Division of Vital

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funeral director,

n 24 hours after death.

e Funeral Director; Aftered filled in by the fur

within 24 hor To the Funer completed fil

Hospital

Certificate: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8. bert 10:30 AM 10h 2011 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert TWITIN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 06/01/1944 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 € M 2 □ F 011-34-4729 67 Director WI Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Example: must be notified at Prince Frederick MD Calvert 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 1780 Twirly Court USA Funeral death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examina Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify SpecifWhite 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dishwasher Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Ebert Bertha Little 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Donohue/Sister 1780 Twirly Court, Prince Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final journey crem. 7/6/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Dorota Marshall 4. Maismall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DOOT disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting indepth), act Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. □Yes 2□No as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed 1 ☐ Yes 2 2 No 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HNo this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 ThNatural 5 Pending investigation death. spital or Attendi nours after death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 238 Merrimac rince Fren

Registrar

DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 201 Medical 4a. Facility Name (if not institution. 4b. City, Town, or Location of Death 4c. County of Death Examiner HO 5A If Under 1 Year 7. Age (In yrs. last birthday) If Under 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min 05/24/1955 218 64 2723 **Director** OHIO Usual Residence of Decedent show 10a. State 10b. County with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD BALTIMORE ROSEDALE 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5801 HAMILTON AVENUE 21237 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MECHANIC BUS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ **FILIPPOS** FILIPPOU MARIANTHI ANASTASIADOU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARMEN FILIPPOU/WIFE T. 5801 HAMILTON AVE BALTIMORE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State OAK LAWN CEM injury or 1 X Burial 2 Cremation 3 Removal from State 7/7/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the b 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death i signed by the aid be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a Was an prior to completi death? perform 1 Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: ြု ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) er of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work?
1 Yes 2 No Accident Investigation 24 hours after death e Funeral Director Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29c. License number 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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who completed cause of death (Item 23a) (Type, Print) OUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician July 2, 2011 8:30 P Leonard M. Fries Sr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manor Care Health And Rehab Towson 8. Date of Birth (Month, Day, Year) Aug 26, 1933 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Country) 1**XX**M 2□ F 77 215-28-4719 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 305 E. Joppa Rd. **Funeral** 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status . Black, White, etc. 1 XX es 2 □ No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes **XX**□ No Specify. White ģ 3 ☐ Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Eula Mae Baugher ပ္ Leonard Luther Fries 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 6408 Brinton Rd., Fork, MD 21051 Jacqueline Gerhardt Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 **XX**Cremation 3 **XX**Removal from State July 6, 2011 | Baltimore, MD 4 □ Donation 5 □ Other (Specify) **Bayview Crematory** 22. Name and Address of Facility
Fink Funeral Home, P.A. 21. Sign 1673 of Funeral Service weo K Gregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Cerebro Vascular Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 힏 in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Records, P.O. the 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? Yes 2 No certificate Vita 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4₽ Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ ō 27. Manne of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Division (Month, Day Year) Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 07-04-11 address of person who completed cause of death (Item 23a) (Type, Print) 7505 Hirpara 05/py Jayant 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Nettie Month 1033 AM 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 - M 2 XF Months Davs Director 216-12-2313 90 Marvĺand March Usual Residence of Decedent 28a-f shov with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Howard Columbia 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7080 Cradlerock Way, 21045 USA filed within 72 hours after death val Hygiene. d other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Decedent 2.5. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ø Salad Chef Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve and Mental is marked ၉ Herman Kolpack Grace Pierpoint 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Ferris/Son Violet Court, Mt. Airv. MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery 7/1/2011 Fulton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. punico & M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ ascendina cholong disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury Exami that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exc Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tinknown 24b. Were autopsy findings available prior to completion of cause of death? failur 24a. Was an autopsy -twombory 1 ☐ Yes 2 ☑ No Yes 2 No Division of Vital 25. Was case referred to medi Be 26. Place of Death (Check only one) examiner? 2**X X**No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be hours after dear ineral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) In 27 2-11 M.D. 000661.1 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044 10710 Charter Drive, 310, Columbia, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State Registrar 7601

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32. Registrar's Signa

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011^{Year} July Day Lois Elaine Fisher 4 4:15 РΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 125th Street Ocean City Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🕇 F Months Min. Days Hours New Jersey **Director** 136-34-7038 67 Yrs 1943 Usual Residence of Deceden shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21015 725 Winterfield Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John (nmn) Hulsebos Nell (nmn) Voqel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Winterfield Ct., Bel Air, Maryland 21015 Dennis Fisher / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp; 7-6-2011 Towson, Maryland Signature 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the diseashock, or heart failure ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Second 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) s after deu. ral Director. After u. hv the funeral d After this Residence 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation

Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 12011

Registrar

DHMH 17 Rev 7/2009

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and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra 's Sign

Smaldore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G918 8/05/2011 TH State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 Day Nicolas Falu-Benitez Jun<u>e</u> 2011 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Bloom Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 🔀 M 2 🗆 F Hours Min 01-10-1923 91 88 Yrs. Director 123-20-1095 Puerto Rico Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5510 Harvest Scene Court 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 🕱 Yes 2 □ No Specify: Puerto Rican If Yes, Give Specify: Puerto Rican 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with th and Mental Hygien 7 is marked other th Line of Typing Printer Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pastora Benitez Gregorio Falu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 11903 Meadow Vista Way Clarksville, MD 21029 Marisol Benitez (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Columbia Memorial Pk. 7-2-2011 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc. MULZ83 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Inter the disease or complications that caused shock, or heart failure. L. t only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final 9nset and Death Atheroscleibtic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 1ea 18 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Records, P.O. Box 68760

The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical nding physiuse as the t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No I or Attending Physician: Tafter death.
Director: After this certifice 25. Was case referred to medical Be the funeral director, 26. Place of Death (Check only one) Hospital: 1 Yes 2 KNo ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Residence 1 Other (Specify) ASSISTED LIVIA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie

Division of Vital Records. To the within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar Lane 31. Date filed (Month, Day, JUL 0 7 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUHE PM Martillus Gary Flichman 2011 3:47 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 🗶 M 2 🗆 F No Worth Pay, Y13950 Maryland **Director** 216-52-5786 60 Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Yes 2 🗆 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3600 Malden Avenue 21211 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Ho 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by ☐ Yes Baltimore, Maryland 21215-0036 white If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) stock clerk grocery store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martillus Gary Flichman Sr. Mildred Kelbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Hulbert - niece 3600 Malden Ave; Baltimore, Maryland 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite cemetery, crematory or other place) injury o Signiture of Funeral Service Linens Rona 22. Name and Address of Facility State Anatomy Board Dixector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Postobst Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed?
Yes 2 No certificate has 1 🗌 Yes 2 🔲 No s after death.

al Director: After this certificate to the funeral director, pr Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No M Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Muhamed Josevenic, MD JUHE, 27,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myhomed Jasarevics

State Registrar Union Meruonal Hospital

JUL 07

31. Date filed (Month, Day, Year)

, 201 University Parkers

BALTIMORE,

MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Harold Frank Leonard July 1:00 PM 2, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 110-24-2926 81 Days Min. 1 M 2 - F 01/24/1930 **Director** Yrs. NY Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Pomona East #506 21208 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X Xo Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Biochemist Education 12 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Reba Silverstein 2 Louis Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Chemin de Ronde, 78960 Voisins le Bttx Audrey L. Frank Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State remetery, crematory or other place)
Final Journey crem. 7/5/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aurtic stenosis Severe Ph_sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last burial-trans and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery been signed by the atte should be detached for in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No After this certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. Te Funeral Director: After the Pleted filled in by the funera 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1- Natural 5 Pending work 2 Accident Μ 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death Item 23a) (Type, Print)
11. A. R. Ley Gbinc 16701 N. Chinde, St. Balto. M. 21205

DHMH 17 Rev 7/2009

State Registrar

			1 - For State Registrar	State of Ma	ryland		irtment <i>tificate</i>			and Me		giene Reg. No.		214	53		
	Physici /Medic		1. Decedent's Name (First, Middle, Last			For	res	te	V		Date of Dea Month	Day	Year 2 0 1				
Examine			4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City						n/a 9. Birthplace (State or Foreign		Farrier		
	Funeral Director		5. Social Security Number 6. Security Number 214–54–8075	M 2 \square F	62	ast birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min. 0	Date of Birth (Month, Day 1/16/	Year) 949	MD	ntry)	roreign		
	Maryland	tor	10a. State 10b. County MD n/a	ı	10c. City	, Town or Loc Balt	imore							10d. Inside Cit			
	with the 23a or 28a or 28a or 28a or 28a	al Director	10e. Street and Number 4 North Central Av		10f. Zip-Code 10g. 0						of What Cou	intry?					
36 s after deat	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Jucation de completed) College (1-4 or 5+) If a. Deced (Give k life. D		Nas Decedent of Hispanic Origin? (Specify Yes or Nof Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black							
21215-0036	thin 72 hour e. an "natural' Medical Ex	Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			16a. Deced (Give life. L	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry						
	should be filed wi and Mental Hygien s marked other th iumatic event, the		17. Father's Name (First, Middle, Last) Haley Forrester			Lab	orer				First, Middle,	Maiden Si	dscap:	ing			
6, ₹	nd 2 should be Ilth and Mental 27 is marked (r traumatic ev	ပ	19a. Informant's Name/Relationship (T			1	-		and Numbe	er or Rural F	Route Numbe	er, City or 7	Fown, State, Z				
	permit. Pages 1 and 3 Department of Health Important; If item 27 any Injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Department of Depa	Removal from State	C	lace of Dispo emetery, cren dent C	natory or oth	ier place		7.7.2			tion - City or ver, M		_		
Balti	permit. Departn Importa any Inju		21. 1g atule of Fureal ervice ee 22. Name and Address of Facility John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD								tors, 1	21215					
	Physician /Medical Examiner	8	shock or heart failure. List only one cause on each line.										Approximate Interval Betv Onset and E	veen			
760,	certificate be executed ding physician and use as the burial-transit	by Physician/Medical Exan	edical	dical	Social desires to contout, and the second se	Due to (or as a Due to (or as a d.	a consequ	ence of):									
O. Box 68	death certific e attending p ed for use as			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 - Fetal	death 3	Ectopic pro					23	d. Date of del Month		Year	
rds, P.O.	uires t signe Id be		Fait ii. Other significant conditions continuous to death but not resulting in the underlying cause given in Fait i.								o the cause of cobably 4 🗍 L						
Reco	g h	Completed								_	24a. Was a autop perfor 1 Yes		prior to death?	utopsy findings completion of c			
/ita	sician: The certificate irector, pa	Be (25. Was case referred to medical examiner?							of Death (C	n (Check only one)						
7	Physician: this certifica eral director,	မ	1 ☐ Yes 2 🗹 No	Hospital: 1 Inpatie		ER/Outpatien			4 🗆 Nu				Other (Spec	cify)			
	Attending at death.	Certification:	27. Manner of Death Natural 5 Pending	be 28e Place of injury - At home farm str			Work? M 1 □ Yes 2 □ No reet, factory, office 28f. Log			d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)			aber,				
	the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	edical Ce		rsician: To the best o iner: On the basis of and manner sta	examinat										s)		
	To the within 2 To the comple	Med	29b. Signature and title of certifier	Feb.								d. Date signed (Month, Day, Year)					
}_			30. Name and address of person who NJRW PATEL								orth Wo		7	ore, MD,	21287		
	Sta	ate	31. Date filed (Month, Day, Year)	72. Registra	r's Signa	ure Sar	Kal										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 234/M ou the Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death nty of Death HOWARD Genera olumbia 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 1 F Min 10-26-1917 197-10-8898 Director 93 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FL 1 □Xes 2 □ No Pasco New Port Richev 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34652 4209 Richmere Drive United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 7 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Public Health Dept other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o Mabel Elizabeth Stanton William Thomas Box 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other tram Ruth A. Upright/daughter 4614 Doncaster Rd. Ellicott City MD 21043 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
St. John's Lutheran 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/8/11 Honesdale, PA 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signeture of Funeral Service Licensee Ellicott City MD 21043 4112 Old Columbia Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Asheroscheroha disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò Day Year 4 ☐ Pregnant at time of death g ☐ Unknown peu the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of ce of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#9perfn g917, 7-8-11 d.o. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arthur July Medical Grossnickle 12:10 Glen 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Health Care Frederick Frederick 5. Social Security Number If Under 7. Age (In yrs. last birthday) **Funeral** 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) MD 1 X M 2 | F Months Davs Hours Min. Director 215-36-6367 84 192 Jan. Usual Residence of Decedent ams 23a or 28a-f show r must be notified at show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9525 Liberty Rd. 21701 U.S.A. items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Force ō 1 Never Married 2 X Married Black White etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: "natural" 3 Divorced 4 Divorced Specify. Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. public Elementary/Seconday (0-12) College (1-4 or 5+) the 10 farmer/ custodian agriculture/ traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ည Daniel R. Grossnickle Carrie S. Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 i any injury or other tra Jean S. Grossnickle/wife 9525 Liberty Rd. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gard. 7/11/2011 Frederick. 21. Sign up of F eral Service Licen 22. Name and Address of Facility Hartzler Funeral Home Jan 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) mir Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 as) attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day the Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed? certificate Yes 2 rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 00 မ this funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 003/051 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Gene Ashe 10200 Coppermine Rd. Woodsboro, MD 21798

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 456 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Mary Μ. Hoh1 2, 4:55 P M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Days Hours 8/15/1928 **Director** 212-26-3504 82 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo r 28a-f st notified Maryland Baltimore Cockeysville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10315 A Malcolm Circle 21030 U.S.A. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items may injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No If Yes, Give Year or Dates. 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Gov't Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Mary Gertrude Burnham Howard Albert McNeave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10315 A Malcolm Circle Cockeysville, MD 21030 Truman H. Hohl / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 7/6/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be MARY (42) | Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cher (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number completed cause of death (Item 23a) (Type, Print) d Timonium MD 2/093 2300 Du State Registrar

11-04818 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jennifer Hamilton State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Date of Death 3. Time of Death Physician/ Hamilton Jennifer Elizabeth 2157 hrs Medical Examiner June 28, 2011 4a. Facility Name (if not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death 1106 Locust Street Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** If Under 1 Year If Under 24Hrs. 187-60-4848 Months Days Hours Director 04/27/1975 36 2**X** F Country) 1 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Dorchester Cambridge tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Locust Street 21613 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 4 X Divorced If Yes, Give Yeer White 1 Yes 2 X No specify: Specify: Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: Witem 27 it marked other than "natural",
injury or other traumatic event, the Medical Examiner. ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales 12 Customer Service Representative Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Larry H. Curry Gloria Faye Be ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Necterine Trail, Clermont, FL 34714 Larry H. Curry-father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/07/2011 Mount Hope Cemetery Aston, PA Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral William Home, Towson, MD 1050 York Rd., 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Retween Onset and /Medical Death a. Shotgun Wound of Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit cian/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for Unknown ţ a signed by the Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been s , page 2 should b 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes No 27. Manner of Death 28a, Date of Injury FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self 1 Natural FOUND: 5 Pending 1 Yes 2 V No within 24 hours after death. the To the Funeral Director: Jun 28, 2011 2057 hrs 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1106 Locust Street , Cambridge, MD (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.F. June 29, 2011 30. Name and address of person who completed cause of death (Item 23a)

108h

State 31. Date filed (Month, Day, Year) Registrar

OCME

Ana Rubio MD.

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 2011 Wayne Danny Hancock July 12:14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 601 Bayberry Court Edgewood Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Dec. 12, 1 🕱 M 2 🗆 F Months Days Min. Year) 1948 Michigan 375-50-1660 Director 62 Usual Residence of Decedent show 10b. County 10c. City. Town or Location Director items 23a or 28a-f sl ner must be notified 1 🗆 Yes 2 🔀 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 601 Bayberry Court 21040 USA "natural", or iten edical Examiner 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces? Black White etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ည Thomas Everette Hancock Pearl Inez Ward and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other train Karin Hancock / Spouse 601 Bayberry Ct., Edgewood, Maryland 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Air Memorial Gdn 7-8-2011 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical _ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t performed certificate 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Natural 28d. Describe how injury occurred 5 Pending Accident within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O D66912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Venkata Parsa 602 Atwood Road, Bel Air, MD 21014 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens for State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) ZGOM Physician/ Medical c. County of Death **Howard** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia A Dawn Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Y Nov. 25, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 🎗 F Months 74 1936 New York 126-28-0671 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Columbia Maryland Howard 1 X Yes 2 No 10f. Zip Code 21044 10g. Citizen of What Country? 10e. Street and Number ò ms 23a or must be r Funeral 4994 Beaverbrook Road ural", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir δ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: **Black** Completed 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ed w...

Ji Hygiene.

Jd other the
c event, the Elementary/Seconday (0-12) Sollege (1-4 or 5+) U.S. Postal General Accounting Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Blanche Jetter ဂ္ Walter Lee 19a. Informant's Name/Relationship (Type, Print)

Karen Hinton - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 5010 Castlestone Drive, Rosedale, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any injury or once, Laurel, Maryland 06/30/2011 Baltimore Wash. Crem. . Signature of Funeral Service Livenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045 M01283 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or shock, or heart failure. List or Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal deat
 Pregnant at time of death in the past 12 months? signed by the atte 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autonsy death? performed Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Aff
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title q ertifie June 28, 2011

State Registrar

07 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arvind Desai

D0063145

705 Digital Dr. Suite#G, Linthicum, MD

21090

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ Haye E Isie 150r Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner alt more artimore 170 Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 F Months Days Hours (Month, Day, Yrs **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Xes 2 No altimore Ltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 2120 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 6 ia 12 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Harris Ellicott -111 MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a ■Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) oweo uneral Service 4600 Heigh alto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Cardiomyopath Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or). the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 cate has been signed by the attending propage 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskyapahrem.D 00057465 7/5/11 -Baltimore, MD. 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203 N.S. Rajapakre, M.D. 2835 Snith AV 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

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	4	_ State	or iviaryianc	•	tificate of Death		2011	21461		
		Registrar 1. Decedent's Name (First, Middle, Last)			inodio or Bodin	2. Date of Deat	eg. Nó h	3. Time of Death		
Physicia Medio		Carn	nen Hoyos			Month July	1, 2011 Year	8:27PM M		
Examiner		4a. Facility Name (if not institution, give street and nu		4b. City, Town, or Location of Death		4c. County of Deat				
		12901 Churchill Ridge Circle			Germantow			tgomery		
Funeral Director		5. Social Security Number 215-96-8302 Usual Residence of Decedent 6. Sex 1 □ M 2 X F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, April 1	2,1917 9. Birt	hplace (State or Foreign intry) Colombia		
points ago is an a suburation to the point and a point and a point and a point and a point and what I hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	p	10a. State 10b. County	10c. City,	Town or Lo	cation			10d. Inside City Limits		
	Funeral Director	Maryland Montgomery			Germantown		1 ☐ Yes 2 🔀 No			
		10e. Street and Number			10f. Zip Code	· .	10g. Citizen of What Country?			
	ner	12901 Churchill Rid			20874		nited State	es/Colombia		
or iter		11. Marital Status 12. Was Dec Armed F 1 Never Married 2 Married 1 Yes	cedent Ever in U.S. orces? 2 2 No	13. \	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
ral", c	ed by	3 X Widowed 4 □ Divorced If Yes, G	ive	1	X Yes 2 □ No Specify:	ombian	Specify:	White		
'natul dical	Completed	15. Decedent's Education (Specify only highest grade completed	- 1	16a. Deced	dent's Usual Occupation kind of work done during most of work		16b. Kind of Business			
ne. than '	E I	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retired)	ing				
Hygie other	Be C	12 17. Father's Name (First, Middle, Last)			Homemaker 18. Mother's Nam	o /First Middle A	Own Home			
ental ked c	횬	Manuel V	elez		16, Mother's Nam	, ,	esus Zavala	a		
s mar		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street and Number or Run					
alth and 127 is		Angela Hoyos/ Granddau	ghter		ng Address (Street and Number or Run 12824 Clarksbur Clarksburg, Mar	g Squaré yland 20	Road #408 871	,		
of He If item or oth		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from	20b. Pla		sition (Name of	Date	20c. Location - City or			
tment tant: jury o		4 Donation 5 Other (Specify)	of	Heave	n Cemetery ; b,	uly 2011	Silver Spri	ing, Maryland		
Depar Impor any in		21. Signature of Funeral Service Licenses	√ M003	35	Name and Address of FacilityRob Rockville, Inc. Rockville, Maryl	ert A. P	umphrey Fur 0-2805	neral Home/ V Avenue		
		23a. Part 1. Enter the disea mr lications that shock, or heart failure. List only one cause on e	caused the death.	Do not ente				Approximate Interval Between		
ysician/	П	Immediate Cause (Final disease or condition Debility								
Medical xaminer		resulting in death) Due to (or as a consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate b. Diabetes Mellitus Type II Due to (or as a consequence of):								
nsit	Examiner	Cause, Enter Underlying Cause (Disease or iinjury	(or as a conseque	ance on,						
/sician and e burial-transit		that initiated events c Due to	(or as a conseque	ence of):						
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ding p	Physician/Med	IF FEMALE:	utcome of pregnance	CV						
atten for us	ciar	in the past 12 months?	Birth 2 Fetal o	death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year		
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cate h	ပ္ပြဲ					perform 1 \sum Yes	ned? death? 2 No 1 ☐ Yes	2 🗆 No		
certifi	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			26. Place of Death (Check					
r this	은 .:		1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Uther: 4 ☐ Nursin 28a. Date of injury ☐ 28b. Time of ☐ 28c. Injury at				ng Home 5 X Residence 6 🗀 Other (Specify) 28d. Describe how injury occurred			
ath. r: Afte e fune	icat	1 Å Natural 5 ☐ Pending (Mon 2 ☐ Accident Investigation	nth, Day, Year)	injury	work? M 1 ☐ Yes 2 ☐ No	200, 20001120 110	Ba. Describe now injury occurred			
recto	Certificate:		e of Injury - At hom ling, etc. (Specify)	ne, farm, stre	eet, factory, office		reet and Number or Rur	al Route Number,		
urs aft ral Di lled in						City or Town				
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examiner: On the ba	asis of examination a	and/or invest	occured at the time, date and place, ar igation, in my opinion, death occurred a leath occurred at the time, date and place	t the time, date an	d place, and due to the o	ause(s) and manner stated.		
withii To th comp		29b. Signature and title of certifier			29c. License number		9d. Date signed (Month			
		1 (John	\bigcirc		D37142		July 5	, 2011		
. 2		30. Name and address of person who completed cau	·	, , , , ,	,					
Stat	0	Geoffrey Coleman. M.D. 31. Date filed (Month, Day, Year)	1355 Pic		Drive, Rockville,	Marylan	d 20850			
Registra	-	JUL 0 7 2011 2		ha	Kel					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 30, Day 2011 Year Evelyn Alice Hall 1:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 401 King Farm Boulevard, Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min New Jersey 151-34-4138 Director 65 October 1945 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 King Farm Boulevard, #203 20850 United States Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pediatrician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Manning Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Smith-Koditek/Sister 38 Maryland Avenue #323, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $\mathtt{Julv}^{^{\mathsf{Date}}}$ cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 - a. Mulhon M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physici n Pancreas Cancer disease or condition resulting in death) years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the ituneral director, page 2 should be detached for use as the burial-transi Dause (Disease or impur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No

9 Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 TYes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🎇 No Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred X Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) D32407 June 30, 2011 P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D. 6420 Rockledge Drive, Bethesda, Maryland

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ 11:50 A^M 2011 Evelyn Watkins Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 14, 1919 Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours West <u>Virginia</u> Director 91 <u>232-24-4827</u> Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2250 John Selby Rd. 21776 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Inforcant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) drycleaning 12 owner/operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alton Brook Watkins Rose Teets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Stephen Horr/ son 2250 John Selby Rd. New Windsor, MD 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 XRemoval from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 7/9/2011 Memorial Park: Clarksburg, WV 21. Sign to read Funding Service Licens 22. Name and Address of Facility Hartzler Funeral Home Marine as 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 ☐ res 2-5 9 ☐ Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No Yes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending 5 Pending work? 1. ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, JUL 0 7 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month mond /Medical 0 2011 4a. Facility Name (If not institution, give street and n 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Randallstown Randallstown Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year)
July 26, 1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1 € M 2 □ F unk Director 213-54-3870 61 1949 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9109 Liberty Road Funeral 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Randallstown 9109 Liberty Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ▼ Other (Specify) in state 21. Signature of Euneral Service Licensee Hona Ld S Wade Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythus Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed aran ora 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an an autopsy page 2 2 No To the Hospital or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending after death. investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year)

Registrar

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31. Date filed (Month, Day, Year)

barta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature.

Arnoont

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:30 A Maggie D. Johnson 201 28 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Holly Hill Nursing Home Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year 1 □ M 2 💢 F **Director** 94 241-20-5154 191 Usual Residence of Deceder 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Baltimore Towson MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or must be r Funeral USA 4805 Midwood Ave. 21212 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Specify: Completed 3 X Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UKN than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Semstress Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ daggie Johnson Grace Cloud Walter Reese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4805 Midwood Ave. Baltimore, MD 21212 19a. Informant's Name/Relationship (Type, Print) Sharon McCleod- Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burlal 2 ☐ Cremation 3 ☐ Removal from State 7-5-2011 Woodlawn Cemt. Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. F/H 21202 22. Name and Address of Facility March 1101 E. North MDAve. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are est shock, or heart failure. List only one cause pn gach line. Approximate Interval Between set and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and burial-transi or as a consequence of attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Yes 2 D signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 2 🗌 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 2 🗌 No Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gurntlying huma Fraction of To the cess of my investigation and out of the cause (s) and manner of stated. (Check 29b. Signature and title of certifier

Registrar

of death (Item 23a) (Ty

Registrar's Sign

dates of person who completed cause

7

31. Date filed (Month, Day, Year,

icense number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 Month Physician/ JUNE LISA JACKSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 9. Birthplace (State or Foreign Country) VIRGINIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5 Social Security Number 6 Sex Age (In yrs. last birthday) Funeral OCT. Pay, Months Hours 1 🗆 M 2 🗖 F 53 215-18-1610 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy njury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State Director MD. BALTIMORE 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number VIOLET AVE APT 407 N USA Funeral 2501 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DIS A BLOD Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ JACKSON SHIRLEY G. GOODMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 N. EAST ST APT BY FREDERICK IMD ZITOI JACKSON AARO N SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

FAIRVION COMETTALY 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 5, 2011 FLODERICK MD ARY L. ROLLINS FUW. HOME FREDERICA MO 21701 GARY L. 21. Signature of Funeral Service Lion see 22. Name and Address of Facility SOUTH ST W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Right-sided heart failure disease or condition resulting in death) 6278 Medical Due to (or as a consequence of): Examiner Pulmonary hypertensi TARRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 $ot\in$ Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached fi Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown acute renal failure 1 🗌 Yes been sir Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) within 24 hours atter usass...
To the Funeral Director: After th' funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 35106 2011

Registrar
DHMH 17 Rev 7/2009

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State

400 W

~32. Registrar's Signature

74h SH

Frederick, MD 2170

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nam

Hee

Myung

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy D. Jones Month July Day 201^{Ye} 12:30PM 5 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death **Timomium** 4c. County of Death Stella Maris Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 214-72-1841 1 🗆 M 2 🗶 F 74 Months Days Hours Director Usual Residence of Decedent shov 10b. County N/A 10a. State ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location Baltimore 10d. Inside City Limits Completed by Funeral Director MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5307A Valiquet Ave 21206 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Armed Forces? A Tacki White etc. 1 Yes 2 X No Specify: If Yes Give Specify: Amer. 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Retail Important: If item 27 is marked other than life. DO NOT use retired)
Sales Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Doretha Anderson Rockwell Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5307A Valiquet Av, Balt., MD 21206 Elizabeth D. Jones/Daughter Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Glen Burnie, MD permit. Page 1 and Department of H 7/15/11 1 Burial 2 Cremation 3 Removal from State cedar Hill Cem. 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt. 21. Signature neral Service Licen 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any solid process, cause. Enter Underlying Cause (Disease or iinjury Dust to for as a consequence of the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of investigation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 안 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 02 2011 FRANCES DIANE JOHNSON - JACKSON 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCREST HOSPICE CENTER BALTIMORE TOWSON 5. Social Security Numbe If Under **Funeral** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 01-30-1956 220-64-5588 Country) Director Yrs 55 NC Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1207 MOSHER ST. 21217 U.S.A. death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 72 hours after Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: BLACK event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE WIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I ည GEORGE H. JOHNSON CORA WARREN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 st partment of Health a portant: If item 27 is y injury or other tra DARRYL JACKSON/HUSBAND 1207 MOSHER ST. BALTIMORE, MD 21217 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 07-11-2011 KING MEM. PARK BALTIMORE, MD re of Funeral Service Licer 22. Name and Address of Facility
ILLIAM C BROWN C
I 206 W. NORTH AVE. WILLIAM 1206 W. COMMUNITY FUNERAL HOME P.A. lai 28a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Dooth Ph sician UAR CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 the SB attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes pice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, nours after death.

neral Director; After this ifiled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Suicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a the Funeral C To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) LLW SM and address of person who completed cause of deat (Item 23a) (Type, Print) Md 2120x GBMC 6701 32. Regi State 2011 JUL 07 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Senah Annabelle Jackson 7:45 p M 2011 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3604 Glenville Drive Havre de Grace Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth NOV 3, 1920 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🖺 F West Virginia 223-26-4685 Director 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4043 Conowingo Road 21034 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dolly Jane Childers Charles Robert Hankla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Mitchell / Daughter 3604 Glenville Road, Havre de Grace. MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗖 Removal from State Darlington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7-6-2011 Darlington, Maryland 21. Signatur of Funeral Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. Wir 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ N disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause E ter coerrying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day Year Pregnant at time of death 5 Other (specify) n signed by the a Ild be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 2 🗌 No 1 Tyes the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Daughter's Residence 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Spec မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined in 24 hou. To the Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and some incompanion of the firm, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) ture and title of certifier 29b. Sign 29c. License number 28136 7-5-2011 e and address of person who completed cause of death (Item 23a) (Type, Print) MD DUNCIN 31. Date filed (Month, I State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:40 PM 0 Paul Francis Judge Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Coastal Hospice at the Salisbury 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 025-24-4054 Age (In yrs. last birthday, **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 09/05/1932 Country) 78 **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10d. Inside City Limits 10c. City, Town or Location Director Salisbury MD Wicomico 1 Yes 2 No 10f. Zip Code 21804 10e. Street and Number 10g. Citizen of What Country? Funeral 910 Sapphire court should be filed within 72 hours after death v n and Mental Hygiene. r is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status was becedent Ever III 0.5.

Armed Forces?

1 Styles 2 No
If Yes, Give
Year or Dates. 1952-56 Black White etc. δ 1 Never Married 2 Married 」、いめのの Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fanning Martin Judge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
910 Sapphire Court, Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once. Wife Carole J. Judge Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 Carcemation 3 Removal from State 7/6/2011 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensed Dorota Marshall 22. Name and Address of Eacility Maryland Cremation Services PO Box 1413, Baltimore, MD Maioral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nset and Death Immediate Cause (Final adenocareinoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on ed by the attending physician and detached it ruse as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

• Funeral Director. After this certificate has leted filled in by the funeral director, page 2.9 autopsy performed? Yes 2 No 2 🗹 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔣 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 🖲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the Signature and title of certifie 29d. Date signed (Month, Day, Year) D 29505 07-03-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOSO, M.D. 5302 CHINABERRY DR. SALISBURY, MD 21801 GREGORIO M

DHMH 17 Rev 7/2009

Registrar

11-05019 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sterling Kelly State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 2. Date of Death 3. Time of Death Month July 5, 2011 **Medical Examiner** 1845 hrs 4a. Facility Name (if not institution, give street and numbe 4b. City. Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Country) Months Davs Hours Director 219-13-149 29 1 **X** M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
smit. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black. Armed Forces? White, etc. Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ath river 17. Father's Name (First, Middle, 18.Mother's Name (First, Middle, Maiden Surna Inomas 19b. Mailing Address (Street and Number or Rural Route Number, City wher 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place Burial 2 Cremation 3 Removal from State Nestern 4 Donation 5 Other Specify nature of Funeral Service Licens meral 23a. Part I. Buer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical a. Complications of Multiple Gunshot Wounds Immediate Ceuse (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of); Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transi Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Wes an 24b. Were autopsy findings available eutopsy prior to completion of cause of performed? death? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ✔ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Jun 21, 2011 To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A ___ Natural Subject shot 1542 hrs 5 Pending 1 Yes 2 V No completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street end Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 3700 block Harlem Avenue, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 흅 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) Med and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 6, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month) State Registrar DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:35 AM Ann Elizabeth Rirby 2011 Ju l Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death P.G MACE 503 Drive FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F (Month, Day, Year) 577-62-9002 Director 66 Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10a. State be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director P. G. MD 1 X Yes 2 ☐ No FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 MACE 20744 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK If Yes, Give "natural", 3XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) St. Elizabeth Hospital THERAPIST ÷ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wooding William Tearl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirby Ft. WASHINGTON ASON L. Mace Drive 20744 503 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-8-11 MEMORIAL DUITLAND 4 Donation 5 Other (Specify) incola Signatur of Funeral Service Lice 22. Name and Address of Facility
HACKETT'S PUNDERAL CHAPEL
BLY-Upstaw Street, N.W. w Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner or any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 1 ☐ Yes ∠ ⊾ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sail director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Joselyne Kourtchou.

Jocelyne Kouarchou, m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

D63748

201 EAST UNIVERSITY PARKUMY.

29d. Date signed (Month, Day, Year)

BALT, MD. ZIZI8

7, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible	0117
State of Maryland / Department of Health and Mental Hygiene	2147

		1- For State Registrar		C	ertifica	te of	Death			Reg	g. No.		
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a			hysician: To the be										
To the within To the comple	Medical		miner: On the basis and manner:	of examination stated.	and/or inv	estigation	n, in my opinion	, death occurred	d at the	time, date ar	nd place, and	due to the	e cause(s)
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		my m	, ~				O.C.I	M.E.			July 2, 20	11]
	Ì	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
							Street, Balt	imore, MD 2	21223	3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** James Vincent Kaufman 4,2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITA ST AGNES 12 ALTINOCE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 25, Birthplace (State or Foreign Country) **Funeral** Min. 1⊠M 2□F Months Days Hours 220-20-6647 84 1927 Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examinating Demotified at 1 ☐ Yes 21X No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 435 Westside Blvd 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give 1945-46 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Amarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No ð Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Kaufman Lillian Trcka ဥ 19). Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other traionce. Jane T. Kaufman Westside Blvd. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/8/2011 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. Baltimore, MD 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fusco I Service License Approximate Interval Between Onset and Death Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONDA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. its underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 - Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ped 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTAVE HEBRIT FACLURE, ATRIAL 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed CVA , CORONARY ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate DASEASE 1 ☐ Yes 2 1 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 022114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD PREDERSCR ROAD, # (E)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year BETTY ELIZABETH KESSLER Medical 11/10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL GENESIS HEALTHCARE SEVERNA PARK SEVERNA PARK Social Security Number If Under 1 Year If Under 24 Hrs 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖺 F Hours 0970371921 214-12-4819 89 PA Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2XX No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 130 SLADE AVENUE, #215 21208 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. "natural" 3 XWidowed 4 Divorced Specify Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ LEONARD FISCHER r traumatic BETTY ELIZABETH UNOBTAINABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau SHERRIE CLARK/DAUGHTER 404 DEERSPRING COURT, MILLERSVILLE, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/05/2011 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CONGR. BALTIMORE, MD of Funeral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Due to (or as Jonsequence of): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 Unknow No the Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 24 hours after death.

• Funeral Director: After this certificate is the funeral director, pag 2 No Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Veterans

Hwy millersville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8661

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year Month TERESA **LABUDA** JULY Medical 5:35 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death IVY HALL NURSING FACTLITY BALTIMORE MIDDLE RIVER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) -23-1911 1 □ M 2 🛭 F Months Days Min. 216-46-3537 99 Director MARYLAND Usual Residence of Decedent or 28a-f shov be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE **ESSEX** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1809 WILLANN ROAD 21221 U.S.A. "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GROCERY STORE OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN DEMSKI JULTA OLEZEVEZKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES RICHARDSON/DAUGHTER 1809 WILLANN ROAD ESSEX, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY 7-2-2011 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE. MD CVACH/ROSEDALE FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final ement Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Other (specify) Pregnant at time of death Month Day Year Unknown 9 Unknown been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Director: After this certificate has learneral director, page 2: prior to con death? autopsy perform Hospital or Attending Physician: The 2 **X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21221 Mace Avenue Kwuma 31. Date filed (Month, Day, Year) 22. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOSEPH WALTER LEWANDOWSKI Month 1125 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITA Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days 08/12/1944 Director 212-44-2517 66 MARYLAND Usual Residence of Decedent nan "natural", or items 23a or 28a-f show Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1720 CHESACO AVE 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, 1 X Never Married 2 Married Yes 2 No Yes, Give þ 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Divorced Completed Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PARTS SALES 12 AUTOMOTIVE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN W. LEWANDOWSKI AMELIA OSTROWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS LEWANDOWSKI/BROTHER 1720 CHESACO AVE BALTIMORE, MD 21237 Department of Healt Important: If item 2 any injury or other I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OAK LAWN CEMETERY! 7/08/11 BALTIMORE, MARYLAND 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of F 1211 CHESACO AVE BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Encephalopathy
Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine frany, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month -Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D006066 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4106 Philadelphia md Pankai Kheterpal Rd BaLTO

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Stephen John Loverde, Jr. 8:15 P.M July. 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6016 Edmondson Avenue Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1⊠M 2□F 215-46-8628 May 13, Director 61 1950 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int; If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exarcing rust be notified at Director 1 ☐ Yes 2 🕅 No MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 6016 Edmondson Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify: White 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen John Loverde Mary Anna Gaitley မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Loverde 6016 Edmondson Avenue; Catonsville, MD 21228 Wife item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Aclantic Crematory 7/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Faperal Service License 1630 Edmondson Avenue; Catonsville, MD 21228 Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nyucardial **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2.☐ No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home S Residence 6 Other (Specify) 1 Yes 2 ₩No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s after dea...
aral Director; Afilled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O Rolling Road Catusirille 1120 N. WoodelV State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month July 3 10:20AM M Gertrude R. Linch Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Collingswood Nursing Center Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min Oklahoma Yrs September 28, 1915 **Director** 95 221-22-8446 Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20850 United States 299 Hurley Avenue #122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ō ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural", Completed 3 X Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hv. Important; If item 27 is marriany or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frederick Robinson Samantha Susan Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. Oberst/ Grandson 6636 Hillandale Road, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date memetery crematory or other place)
Montgomery
Crematorium Inc. 1 Burial 2 X Cremation 3 Removal from State July 2011 atorium Inc. 6, 2011

22. Name and Address of Facility Robert A.
Bethesda-Chevy Chase, Inc.
Bethesda, Maryland 20814-4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Pumphrey Funeral Home/ Signature of Funeral Service 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) physician and the burial-transit Diabetes Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🕅 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of confier 29c. License numbe

State Registrar Rita Gh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghosh, M.D. 14812 Physicians Lane,

D30132

#161, Rockville, Maryland 20850

July 5, 2011

TIOD MARIUS COURT

3 Ectopic pregnancy

5 Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

EMI

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death

Ft. Lincoln Cenetery

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7-12-11

22. Name, and Address of Facility
HACKETS true Chapel
814-Upsaue Street, N.D.

LANGAM.

Md.

Brentwood

DC 20011

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

1 Tes

2 No

1 ☐ Yes

3 No

28d. Describe how injury occurred

24a. Was an autopsy performe

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Yes

26. Place of Death Check onl one

Approximate Interval Between Onset and Death

Year

3 Probably 4 Unknown

. Were autopsy findings available prior to completion of cause of death? 2 No

28e-f show treumatic event, the Medical Examiner has be notified at or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural!" or hours injury or other treumatic event

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10a. State

MID

19a.,Informant's Name/Relationship (Type, Print)

1 Burial 2 □ Cremation 3 □ Removal from State

/Daughter

vonce Crawford

4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License

20a. Method of Disposition

Immediate Cause (Final

in the past 12 months?

1 Yes 2 No
9 Unknown

examiner?

4 Thomicide

(Check only one)

29a. Certifier

1 ☐ Yes 2 No

disease or condition resulting in death)

Funeral

Director

Pnysician /Medical Examiner

Physician/Medical Examiner þ Be Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 27. Manner of Death 1 Natural

filled in by

Medical

Certification; To

g physician and as the burial-transit esn jo page 2 should funeral director,

Hospitel or Attending Physicien: The law requires that the death certificate be executed

after death.

within 2

Box 68760.

P.O.

Records,

Division of Vital

29b. Signature and title of certifier 30. Name and a of person who completed cause of death (Item 23a) (Type, Print) MEKON

5 Pending

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

D6 (307

1 Tes 2 No

Other:

28c. Injury at Work?

7600 CAR

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julv 201^Yga Maynard E. Moss 7:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death N/A 1028 Wilmington Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 24, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2 □ F Days Hours 214-56-8540 Yrs. Pennsylvania **Director** 60 <u>June</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 1028 Wilmington Avenue **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ğ Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction 10 Truck Driver permit. Page 1 and 2 should be filed w Decartment of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Hildebrant Harry Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1028 Wilmington Avenue Baltimore, Maryland 21223 Jeanne D. Moss, Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XI Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/06/11 Baltimore, Maryland 21. Signature of Funeral Service Liver ee Remarks of Facility Of Maryland, Inc. 1999 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the reshock, or heart failure. List only one card on each line. Immediate Cause (Final Onset and Death Ph sician 0 C disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? 1 Yes 2 🗌 No Yes 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: At 1 Yes 2 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сотріете (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier ne and address of person who comp șe of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Debra Ann Morg		1- For State Registrar	tate of Maryla		partment o ertificate o		d Mental	R	eg. No.	2	21482
Physicia Medical Exami		1. Decedent's Name (First, Midd Debra Ann Mor						2. Date of Dea Month	Day	Year	3. Time of Death 1205 hrs
		4a. Facility Name (if not instituti	on, give street and nu	mber)	Т	4b. City, Town, or	Location of De	July 3, 20 eath		. County of Deat	
		856 Lemmon Street				Baltimore				N/	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		din		Forei	rthplace (State or gn
Director		212-76-7112 Usual Residence of Decedent	1 M 2 F		55 Yrs			April	23,	1956 c	ountry) Maryland
any		10a. State 10b. County		10c. C	ity, Town or Locat	tion			.		10d. Inside City Limits
Aaryland 28a-f show 1 at once.	5	Maryland N	/A		Balt:	imore					1 X Yes 2 No
Maryl	rect	10e. Street and Number				10f. Zip Code		1	0g. Citiz	zen of What Cou	intry?
with the Maryland ms 23a or 28a-f sho be notified at once.	iO le	856 Lemmon Str				21201				USA	
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be neitified at once	Funeral Director	11. Marital Status 1 Never Married 2 X M	larried Armed Fo	400	If Y	as Decedent of His res, specify Cuban)-	Race - Amer White, etc.	rican Indian, Black,
ifter de la constant		3 Widowed 4 Di	1 Yes	2X No		Yes 2 X No	specify:		1	Specify: Whi	te
5-0036 iled within 72 hours a Hygiene. I other than "natural the Medical Examin	ed by	15. Decedent's Education (Spe		le completed)		nt's Usual Occupati			16b. K	(ind of Business	Industry
36 in 72 l	plet	Elementary/Secondary (0-12)	College (1	-4 or 5+)			DO NOT USE	retired)			
5-003 iled withi Hygiene. d other th	Completed	10 17. Father's Name (First, Middle	, Last)		Age	ent T	18.Mother's Na	me (First, Middle,			roperties
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MD 21215-0036 to 2 should be filed within 7 thin and Mental Hyggiene. In 27 is marked other than aumatic event, the Medica	ဥ	19a. Informant's Name/Relations			0.00	g Address (Stree					
		Dennis Markwo 20a. Method of Disposition	od, Son	208		Link Aver		timore,		land 21	
Baltimore, permit. Pages I ar Pepartment of Her important: If ite		1 Burial 2 X Cremation		om State	crematory or ot	her place)				_	
Baltimor permit. Pages I Department of I Important: If injury or other		Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee Thoma	e Gree	or 22.1	natory Ir	of Facility	7/07/11	Ba	Itimore	, Maryland
		Thomas	Dur-		29	emation S 9 Frederi	ociéty ck Roa	Ot Mary d Baltim	Land ore.	l, Inc. Marvla	nd 21228
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	complications that ca on each line.	aused the dea	ath. Do not enter t	he mode of dying,	such as cardia	c or respiratory arr	est, sho	ck, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)				ion					Death
h-		Sequentially list conditions,	Due to (or as a b.	consequence	e or):						
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lox 6876 leath certificate a attending phy for use as the b	M/m	IF FEMALE: 23b. Was decedent pregnant in to past 12 months?	he 23c. If yes, o	outcome of pro irth		tal death 3	Ectopic pred	anancv		. Date of deliver Month	y Day Year
ox 6 eath cer	sicia	1 Yes 2 No 9 V Un	LD0110	ant at time of	dooth -	her (Specify)					
	Physician/N	Part II. Other significant condit	9 011616		t resulting in the I	underlying cause g	iven in Part I	23e Did to	phaccol	ise contribute to	the cause of death?
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ords,	Completed							24a. Was			utopsy findings available
Reco The law icate has	duo							_ autop perfo 1 ✔ Yes	rmed?	death?	completion of cause of
Division of Vital Records, rat or Attending Physician: The taw requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director, page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 2 should be a second page 3 should be	BeC	25. Was case referred to medica				26.Place	of Death (Che		2 NO	1 🗸 Y	es 2 No
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Hosp 24 hou Fune etely fi	calc	29a. Certifier 1 Certifying P	hysician: To the bes	t of my knowle	edge, death occur	red at the time, da	te and place, a	ind due to the caus	e(s) and	manner as stat	ed.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	듛	one) 2 Medicai Exa	miner: On the basis of and manner st	f examination	and/or investigat	tion, in my opinion,	death occurre	d at the time, date	and plac	ce, and due to th	e cause(s)
	Σ	29b. Signature and title of certifie	er			29c. License				ate signed (Mo	nth, Day, Year)
	• [West 20 Name and address				O.C.N	л. ட .		July	6, 2011 	
		 Name and eddress of person Ana Rubio MD. Ass 	who completed caus sistant Medical E			imore Street. I	Baltimore. I	MD 21223			
Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Signa					-		
Regist	_	JUL 0 7 201	1 1	- A.	parker						
DHMH 17 Rev 1/20 OCME 2006	001			•	ORIGINA	L		OCHE			

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Thomas A. Mour		S 1- For State Registrar	tate of Maryla		oartment o		d Mental I		Reg. No.	011	2148
Physicia Medical Examii	ın/	Decedent's Name (First, Midd THOMAS		UNT			_	2. Date of De Month June 30,	ath Day	Year	3. Time of Death 0529 hrs
See A.		4a. Facility Name (if not instituti 1029 Quantril Way	ion, give street and nu	ımbər)		4b. City, Town, or I Baltimore	Location of Dea	ath	4c. Cou	inty of Death	1
Funeral Director		5. Social Security Number 220 92 3961	6. Sex	7. Age (In yrs	last birthday)	Months Days		lin.	7/196	Foreig	thplace (State or gn ^{puntry)} MARYLAN
nd show any ice.	ŗ	Usual Residence of Decedent 10e. State 10b. County MD n/a			ty, Town or Locat						10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f sho	Director	10e. Street and Number 1119 EVANS W	JAV			10f. Zip Code	205		10g. Citizen o	f What Cour	ntry?
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2	盃	15. Decedent's Education (Spe Elementary/Secondary (0-12)		de completed)	during m	Yes 2 X No t's Usual Occupationst of working life.	on (Give kind o	f work done etired)	16b. Kind o	f Business/I	
15-0036 filed within 72 hos I Hygiene. ed other than "na t, the Medical Ex	e Completed	1 2 17. Father's Name (First, Middle WILLIAM M	o, Last) IOUNT	 	D.	ISABLE 1		ne (First, Middle,	Maiden Surna	•	
지 말은 별 하	To Be	19a. Informant's Name/Relations DAVID MOUNT/	ship (Type, Print)			Address (Street EVANS		Rural Route Nu		Town, State	, Zip Code)
s 1 and free free free free free		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other S	pecify:	m State	. Place of Dispos crematory or oth METRO (ition (Name of cem ner place) CREMATOF	RY 7	Date /18/11	20c. Locati	on - City or FIMOR	Town, State
Baltimo permit. Page Department or Important:		21. Signature of F a ervi	2	sused the deat		CHES	SACO A	VE BAL	דאספו	T MD	IERAL HOME
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	rug(met	hadone,						Between Onset and Death
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the funeral	Certification:	3 Suicide 6 X Coul	ding fd 6- stigation	-30–11 of Injury - At h	fd 5:00 nome, farm, street at home	, factory, office bui	es 2 X No	Unknowr 28f. Location (or Town, S Kaltimo	Street and Nu	mber or Rur Quant	al Route Number, City Cril Way
To the Hosp within 24 hou To the Funct completely fi	<u> </u>	29a. Certifier 1 Certifying Pt	hysician: To the best miner:On the basis of and manner sta	of my knowled examination a	dge, death occurr	ed at the time, date		d due to the caus	se(s) and man	ner as state	d.
	Σ	29b. Signature and title of certifie	ronica	-Pol	lee -	29c. License i			29d. Date s June 30,		th, Day,Year)
		30. Name and address of person Patricia Aronica-Pollah	k MD. Assista	nt Medical	Examiner 9	000 W. Baltimo	ore Street, E	Baltimore, M	D 21223		
Sta Registra		31. Date filed (Month, Day,Year)	7 2011	strans, Signati	1. 1	Wel					
DHMH 17 Rev 1/200	1				ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07^{nth} 0^{Day} ŽÖ11 June R. McComas 10:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2X F Min 0671571926 Maryland **Director** 217-20-1828 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important if fiem 27 is anaked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10d. Inside City Limits 10c. City, Town or Location Directo MD Baltimore Timonium 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12246 Roundwood Road #807 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Henry Rightor Lucy Hetrick Rightor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /Husband Arthur McComas 2246 Roundwood Road #807 Timonium MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial A Cremation 3 Removal from State Glen Burnie, MD Atlantic Crematory 7/7/11 4 Donation 5 Other (Specify) 21. Signature of FIL Approvice Licenses 22. Name and Address of Facility Michael J. Lemmon Funeral Home of Dulaney Valley 23a. Part 1. Enter the disease, or complications that caused the death. Do not offer the rise of daily suit a caused or resimply and part 1. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physici n disease or condition resulting in death) I Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, n any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence of) Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical JUne Malomas Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-p onths? Day 5 Other (specify) Month Year Pregnant at time of death Yes No ed by the a 9 Unknown Unknoy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The perform 1 🗌 Yes 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending (Month, Day, Year) work? Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and titl completed cause of death (Item 23a) (Type, 1mm um MD21093 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and numb **Examiner** Town, or Location of Death 4c. County of Death baltimore 9. Birthplace (State or Foreign Country) Virginia If Under **Funeral** If Under 24 Hrs 8. Date of Birth Min. 1 M 2 DXF (Month, Day, Year) 11/07/1928 82 **Director** 225-32-3380 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State should be filed within 72 hours after death with the Maryland 10h. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 919 Spangler Way 21205 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 6 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Joseph Watson Kate Rollins and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 .. Page 1 and 2 sh tment of Health a tant: If item 27 is Walter Mahala - Husband 919 Spangler Way Baltimore, Maryland 21205 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 107/10/2011 Holly Hill Cemetery Baltimore, Maryland 21. Signature of Funeral Serice Licenses 22. Name and Address of Facility Homes P.A. Raltimore Maryland 21231 David J. Weber Funeral 401 S. Chester Street 28a. Part 1. Enter the disease of shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (x as a consequency of) Examiner peumonia Sequentially list conditions, if any leading tank cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has the continuation of the funeral director, page 2 s autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Other: မြ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\mathbf{J}_{\mathbf{u}}^{\text{Month}}$ 3, Kermit Brown Mohn Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2011 O 0446 **Funeral** Sex 1 X M 2 □ F (Month, Day, Months Days Hours Min. Director 216-44-4454 98 July Usual Residence of Decedent show 10a, State 10b. County with the Maryland at 10c. City. Town or Location Director notified 28a-f Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number ò 10g, Citizen of What Country? must be Completed by Funeral items 23a United States 201 Upton Street 20850 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceuci... Armed Forces? Yes 2 X No 7/3 injury or other traumatic event, the Medical Examiner ō 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) United States and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Labor Economist Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Dierwechter Erma Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 8 Oxban Court, Bluffton, South Carolina 29909 Kermit S. Mohn / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. July 7 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland permit. Signature of Funeral Service Licensee M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ my ocardia disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or iinjury signed by the attending physician and deedached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by peen 24a Was an this certificate has performed? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) Deborah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Time of Death

A M

4:46

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 ☐ No

Pennsylvania

 201^{ear}

Montgomery

14. Race - American Indian.

Government

White

Black, White, etc.

Robert Address Tumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9901 medical Ctr or Rockville, mi Sherrill md **ORIGINAL**

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	larylan		artment of He		Mental Hy	giene	1 211.07		
			Registrar 1. Decedent's Name (First, Middle,	(ast)		Cer	tificate of D	eatn	Reg. No.	1 4140/			
	Physicia			1 1 . 1.			2. Date of De Month	Day Ve					
-		Medical Examiner 4a. Facility Name (if not institution, give street and number) Munder1oh Munder1oh					4b. City, Town, or L	ocation of Doo	Jul	y 5, 2011 4c. County of E	12:20A M		
	,		Collingsw	ood Nursing	er		ckville		,				
	Funeral	г	5. Social Security Number	st birthday)	If Under 1 Year	If Under 24 Hr	s. 8 Date of Bir	th a	ntgomery Birthplace (State or Foreign				
	Director		217-24-0883	1 □ M 2 K) F	82	Yrs.	Months Days	Hours Mir	February	^{y, Year)} 1929	Michigan		
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Loc	eation				10d. Inside City Limits		
	laryla ka-f s ified	Director	Maryland Mor		,	,		1 • 1 1			1 ☐ Yes 2 🛣 No		
	or 28	흡	10e. Street and Number	tgomery			10f. Zip Code	ckville		10g. Citizen of What			
	with s 23a ust b	Funeral	14419 Wo	odcrest Dr	ive			20853					
	leath items ier m		11. Marital Status	12. Was Decedent I	Ever in U.S.		Vas Decedent of Hisp	panic Origin? (S	Specify Yes or No-		ed States American Indian,		
36	after (<u>\$</u>	1 Never Married 2 Marri	Armed Forces? 1 Yes 2 X If Yes, Give	No		Yes, specify Cuban, ☐ Yes 2 X No		rto Rican, etc.)		Vhite, etc.		
21215-0036	ours a atura	Completed by	3 X Widowed 4 ☐ Divorced 15. Decedent	Year or Dates.						Specify:	White		
75	72 h	ğ	(Specify only highes	t grade completed)		(Give k	ent's Usual Occupati ind of work done dui ONOT use retired)		orking	16b. Kind of Busine	ess Industry		
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5	5+)	ille. De	Homema	ker		Own	Home		
b	filed al Hy d oth	Be (17. Father's Name (First, Middle, La	st)					ame (First, Middle,		1101110		
<u>yla</u>	ld be Ment arke	2	Chri	stian Willi	am Ko	рр			Jeanne I	rene Stin	chcomb		
Maryland	shou sand ism	U	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address (Street and	d Number or R	ural Route Numbe	r, City or Town, State	, Zip Code)		
e,	and 2 Health		Richard J. Ko 20a. Method of Disposition	pp/ Brother				st Driv	re, Rocky	ille, Mar	yland 20853		
סר	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 K Cremation		20b. Pla	ace of Dispos metery, crem	sition (Name of atory or other place)		Date .T11 T 37	20c. Location - City	or Town, State		
Baltimore,	iit. Pa artmei ortani injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Fun Service Line)	37	<u>C</u>	remato	atory or other place) ery rium Inc.	7	July , 2011	Bethesd	a, Maryland		
Ba	регт П трс any		Jan 1	Fight	M003	35 R	ockville, ockville,	of Facility R c Inc. 3 Maryla	bert A. 300 West and 20850	Pumphrey Montgomer -2805	Funeral Home/ y Avenue		
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	mplications that caused by one cause on each line	the death.	Do not ente	r the mode of dying,	such as cardia	c or respiratory arr	est,	Approximate Interval Between		
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	aDemen	tia						Onset and Death		
	Examiner		resulting in deathy	Due to (or as a		,							
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16	uted d ansit	Examiner	cause, Enter Underlying Cause (Disease or iinjury								, a		
77	execu an an rial-tra	EX	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):		_					
09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d						_			
687	rtifica ing pl e as tl	Me	IF FEMALE:										
×	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🔲 Fetal	death 3 🗌	Ectopic pregnancy				Date of delivery		
	e dea the a	ysic	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	ath 5 ∐	Other (specify)			Month	Day Year		
O.	law requires that the nas been signed by the e 2 should be detach	by Ph	Part II, Other significant condition	s contributing to death be	ut not resul	ting in the un	derlying cause given	in Part I.	23e. Did to	bacco use contribute	e to the cause of death?		
s,	uires t n sign ald be	q pe							1 🗆 \	1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown			
0	w req	let(24a. Was a		autopsy findings available		
ě	he law tte has	Completed							autop perfor 1 🗌 Yes	sy prior	to completion of cause of		
a	ian: T		25. Was case referred to medical examiner?	,			26. Place	e of Death (Che		2 ∆ No 1	Yes 2 No		
5	hysic his ce Il dire	P	1 Yes 2 No			R/Outpatient	3 DOA Other:	4 X Nursing I	lome 5 Resid	ence 6 🗌 Other (St	pecify)		
0	ling P	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day	y 2 Year) 2	8b. Time of injury	28c. Injury at work?	i	28d. Describe ho	ow injury occurred			
<u>S</u>	ttend death death stor: /	을	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	t be				s 2 🗌 No					
Division of Vital Records,	R (0 - 0 !		4 Homicide determine	28e. Place of Inju building, etc	ry - At nom . (Specify)	ie, fârm, stree	et, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,		
	Hospit 4 hour uners	Medical	29a. Certifier 1 X Certifying P (Check 2 Medical Exa	hysician: To the best of a	my knowled	dge, death oc	cured at the time, da	ate and place, a	and due to the cau	se(s) and manner as	stated. ne cause(s) and manner stated.		
	the h	— г	only one) 3 - Certifying N	urse Practioner: To the b	est of my k	nowledge, de	ath occurred at the tir	ne, date and pl	at the time, date ar ace, and due to the	cause(s) and due to the cause(s) and manner	ne cause(s) and manner stated. as stated.		
	₽ ≥ ₽ 8		29b. Signature and title of certifier				29c. License nu		2	29d. Date signed (Mo	inth, Day, Year)		
	24	-	20 Name and advantage		_11 01	0.1/5		30132		July 5	5, 2011		
			30. Name and address of person wh Rita Ghosh, M.D	o completed cause of de 14812 Phys				Rockwi1	10 Mars	1and 2025	0		
	State	e	31. Date filed (Month, Day, Year)	22 0000	de Cianatur			TOCKVII	re, nary	Tand 2007			
	Registra		JUL 07	2011 Snew	لم ر	. pa	No.						

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			1 - State of Maryland Registrar		artment of F tificate of L			giene Reg. No.	1 21488		
	Physicia Media		1. Decedent's Name (First, Middle, Last) Annie Marth				2. Date of Dea Month ひロロ		3. Time of Death		
•	Examir		4a. Facility Name (if not institution, give street and number) Northwest		4b. City, Town, or Windso		ath	4c. County of Death Baltimore Co.			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 1 M 2X F 77	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birt	th s	9. Birthplace (State or Foreign Virginia		
	nd how at	j,	Usual Residence of Decedent	Town or Loc	ation			,	10d. Inside City Limits		
	vith the Maryland 23a or 28a-f show st be notified at	irect	MD N/A	В	altimor	·e	_		1 🔀 Yes 2 □ No		
	with the 23a or	Funeral Director	10e. Street and Number 4409 Wentworth Rd.		10f. Zip Code 2120	7		10g. Citizen of Wh. U.S.A.	at Country?		
9800	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	ed by Fun	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.			spanic Origin? n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian, White, etc. Black		
1215-(ithin 72 hou ene. • than "natu the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade	(Give k life. DC	ent's Usual Occupa ind of work done of NOT use retired) Oay Care	luring most of w	, ,	16b. Kind of Busin			
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours nt of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical I	To Be	17. Father's Name (First, Middle, Last) Enoch C. Thomas			18. Mother's N	lame (First, Middle, Cice Jac	Maiden Surname)	·		
	nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Gladys Fisher (daughter)				Rural Route Number Baltimor				
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		1 🖼 Burial 2 🗌 Cremation 3 🗀 Removal from State	netery, crem	sition (Name of atory or other place	07/	Date 707/11	20c. Location - Ci			
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee	22 12 21	Name and Address oseph H	s of Facility Brov ulton	n Jr. F Ave., B	uneral altimor	Home PA e, MD 21217		
	Physician/ Medical		23a. Part 1. Enter the isease, or complications that caused the death. I chock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent)	Re on	r the mode of dying	g, such as cardi			Approximate Interval Between Onset and Death		
	Examiner	er	Sequentially list conditions								
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. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 🔲	Ectopic pregnancy Other (specify)	/		23d. Date of Month	,		
ds, P.O.	quires that the series of the	ed by Pl	Part II. Other significant conditions contributing to death but not resulti	ng in the un	derlying cause give	en in Part I.		tobacco use contribute to the cause of death?			
Records,	: The law red cate has bed ; page 2 sho	Completed by				24a. Was a autop perfor 1 \(\sum \text{Yes}\)	psy prior to completion of cause of death?				
of Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	2/Outnationt	Otho	ce of Death (Ch		6 20 17	specify)		
n of	iding Phi th. After thi funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28 (Month, Day, Year)	Bb. Time of injury	28c. Injury work?	at		ow injury occurred	г Т		
Division	o the Hospital or Attendin ithin 24 hours after death. o the Funeral Director: Aft ompleted filled in by the fun	Certificate:	2	, farm, stree		res 2 🗆 NO	28f. Location (Si City or Town		r Rural Route Number,		
_	ne Hospit: n 24 hours le Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination are only one 3 Certifying Nurse Practioner: To the bast of my knowledge.	nd/or investic	ration in my oninior	douth occurre	d at the time alate or	al place and due to	the equac/s) and manager stated		
	To the within 2 To the comple		29b. Signature and title of certifier Slyppulm()		29c. License		- 2	29d. Date signed (N	Ionth, Day, Year)		
J			30. Name and address of person who completed cause of death (Item 23 N · S · Rujupn Kee / m · D · 2835	a) (Type, Pri	int)						
	Stat Registra	-	31. Date filed (Month, Day, Year) 32. By otrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27^{Day} Physician/ 06 Month ADAIR CATHERINE MATULAITIS 2011 11:56 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗹 F Months Days Hours 216 18 3099 86 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Funeral Director 1 Yes 2 X No Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 21122 U.S.A. 164 Meadow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White, etc. 0 ģ 1 Never Married 2 Married 2 X No ☐ Ves Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working h and Mental Hygiene.
?? is marked other than "n life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 AWAC Assembler Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frieda Louise Koellner William Anthony Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 164 Meadow Rd. Pasadena, MD Nancy Lee - Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oti 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State New Cathedral Cem 6/30/11 Baltimore, 4 Donation 5 Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home Signature of Sopral Sevice Licensee 169 Riviera Drive Pasadena, 23a. Part 1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Month Year ed by the a detached f P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypertension Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl performed' 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 2 🗆 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A Poleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 6/27/2011 D57313

State Registrar

DHMH 17 Rev 7/2009

Chevrolet Dr.

wer of face

Ellicott City, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Dave,

MI CG ______31. Date filed (Month Day, Year)

Mitul

9055

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death O Month 3. Time of Death Physician/ GEORGE EMERSON MITCHELL 2011 02 1:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth Hours 213 14 9785 1070271922 Director Usual Residence of Decedent show 10a. State 10b. County at Director 10c. City Town or Location 10d. Inside City Limits ems 23a or 28a-f shor r must be notified a' MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 140 Magothy Beach Road U.S.A. items ? within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Armed Forces?

1 X Yes 2 No 1944
If Yes, Give
Year or Dates. 1946 Black, White, etc. 1 Never Married 2 Married ō δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed 1946 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Welder Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of ည William Mitchell Elizabeth Swanson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i 21122 Helen Mitchell - Wife 140 Magothy Beach Rd Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of I ò 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 7/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive 21122 Pasadena, MD 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, of heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ myocardial intarction disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** homic obstructive pulmonary disease Ecquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examir requires that the death certificate be executed and that initiated events resulting in death) Last ng physician a burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day the 8 1 ☐ Yes ∠ ⊆ 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law this certificate has ral director, page 2 a autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛮 No ၉ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Examinations of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

son who completed cause of death (Item 23a) (Type, Print)

July 5,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I tems# 26 per phy 9917.7-7-11 sm State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 5, Virginia Lorraine Owings 2011 11:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2908 Delaware Avenue Baltimore Highlands Baltimore 5. Social Security Number 8. Date of Birth
Jule 9, 1931 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 213-28-7640 Maryland **Director** 79 Yrs Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Pembrook Pines 1 ☐ Yes 2X No FLBroward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7821 Northwest 11th Street 33024 United States permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 X Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Glass Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Harden Alice Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Delaware Ave., Baltimore Highlands, MD 21227 Joy Nickey - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Jul.7,2011 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD Thame and Address of Facility Ambrose Funeral Home, Inc. Sulphur Spring Rd., Arbutus, MD 21227 1328 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed ₁ ☐ Yes 2 LINO 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Daughters 2 L No Other: 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 🕰 6 🔀 Other (Sp 4 Nursing Home 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D31322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIG MAIDEN CHOICE CN, CATONSVILLE, MI 2/22 RANGER GARGO 31. Date filed (Month, Day, Year State JUL 0 7 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July William Pitcher 5. 2011 6:27 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min 1 🗶 M 2 🗆 F Hours MaryTand Director Yrs 215-24-1111 83 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Lutherville 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 2 Woodward Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 Divorced 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Edwin H. Pitcher Harriet Schaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Bruce Pitcher / Son Joel Court Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2011 Towson, Maryland Hilltop Serv. Corp. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service 1050 York Road Towson, Maryland 21204 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician/ Vienella cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed physician and sthe burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy Yes 2 N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Another (Specify) hospie 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 2 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: After the functed filled in by the function. M 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check re and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) 2011 NILL SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amen MO GTOL N. CHURCES ENSON MI) CHANGS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 7/2009

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Box

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Gopies - Are Lagible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1,0 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0 ScoA Theodosius M. Penson une Medical 01 Facility Name (if not institution, give street and+ Examiner 4b. City, Town, or Location of Death 4c. County of Death of tospi Jumber unk Baltimore 12 altimore Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min (Month, Day, Sept 25 1 🕅 M 2 🗆 F Maryland Director 1945 Usual Residence of Decedent or 28a-f show 10b. County 10a. State hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1153 N. Bentalou Street 21216 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 6 þ 1 X Never Married 2 Married Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. b1ack "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) 0 laborer construction Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ပ injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert McGill/cousin 5001 Hesperus Drive Columbia, MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 N Other (Specify) in state Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ripe it failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ocald disease or condition Medical resulting in death) Examiner Eequal tielly list our ditoris, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of 12 To the Hospital or Attending Physician: The law requires that the death certificate be executed Q W310V attending physician and Due to (on as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed lo millat 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 124 hours after death.

Funeral Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No Hospital: 1 Tyes မြ 1 Inpatient 2 Erroutpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Deat 28b. Time of Certificate: 28c. Injury at Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Accide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 8 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26748 Uberou mi June 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL UBEROL MI) 4419 F RO BALTO 419 Registrar's Signature 31. Date filed (Month, Day, JUL 07 State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 1,01 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>2</u>011 10:00P^M Lucille July Gertrude Pheabus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1271 Keysville Rd. South Carroll Detour 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Months Hours 218-38-2593 Yrs **Director** 99 1911 Maryland Usual Residence of Decedent 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Frederick Union Bridge 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 10709 GreenValley Rd. 21791 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 er than "natural", c , the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 housekeeper/cook home for boys permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ Mary Stambaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1271 Keysville Rd., S Joyce Wilhide/ daughter Detour, MD 21757 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/7/2011 Keysville, MD Union 21. Signal of Juneral Service Light 22. Name and Address of Facility Hartzler Funeral Home atharine Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, i i n CONBESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 8 YEARS ATRIAL FIBRILLATION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami COROPARY ARTERY 16YEARS Physician; The law requires that the death certificate be executed and -tran. Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death ed by the a Unknown g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Division of Vital R Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) daughter's Other: 4 Nursing Home 5 Residence 6 X Other (Specify) residence 1 ☐ Yes 2 🗷 No 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 👺 Natural 5 Pending work within 24 hours after death.

To the Funeral Director; A: completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Inlan 5.

31. Date filed (Month, Day, Y

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

20014317

JULY 2, 2011

ONE KINGS DRIVE, TANEYTOWN, MD 21787

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Year MELVIN PARKER HINE 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL <u>ILVER</u> SPRING MONTGOMERY 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year, 577-76-6637 **Director** Yrs. 60 950 WASHINGTON Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If ifew 27.5 is marked other than "natural", or items 23a or 28a-f show they then the Madical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a PRINCE GEORGE'S MD1 XYes 2 No LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 720 WILLOW HILL DR 20785 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🄀 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday College (1-4 or 5+) COMPUTER ANALYST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN SUSIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGORY PROCTER/COUSIN 7720 WILLOW HILL DR LANDOVER. MD20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Denation 5 Other (Specify) CHESAPEAKE 6/30/11 CREM BELTSVILLE. 21. Signature Funeral Service 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE WASH NE20002 complications that caused the death. The not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final Onset and Death Physician/ METASTATIC ANAL CANCER disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit CARDOPULMONARY ARREST that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day Year 1 L Yes 2 L 9 Unknown 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 TNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 1 Yes 2 No Yes 2 YNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 (No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tyes Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

completed filled in by the funeral director, To the within 2

> 31. Date filed (Month, Day, Year) State Registrar

ess of person who cor ANIEDOBE

1500

(Check

29b. Signature and title of certifier

(Type, Print) GLEN RD SILVER SPRING, MD.

FOREST

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D66162

29d. Date signed (Month, Day, Year)

6/27/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Margaret Johanna Paone 2011 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 05/16/1942 1 M 2 J Months Hours Country) 212-40-6377 69 **Director** Usual Residence of Decedent ems 23a or 28a-f show r must be notified at f shov the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No 10f. Zip Code 21221 10e. Street and Number 10g. Citizen of What Country? 2220 Silver Lane Road Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ **X**o If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or ite the Medical Examiner Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Blacksmith Milton Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Aitken/Son 4059 Bay Park Dr., Liverpool, NY 13090 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 7/4/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Servi
PO Box 1413, Baltimore, Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box in the past 12 months?

1 Yes 2 X No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 🕱 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28c. Injury at work?
1
Yes Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) injury X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accider ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Reactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, 2300 DULANEY VALLEY RD. MD TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, JUL 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Donald Quinn 6:42 Medical July 701 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2040 N. Rolling Road Woodlawn Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Min. Months Aug. 3, 1926 Hours Massachusetts 026-20-3946 84 Director Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2040 N. Rolling Road 21244 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1944-46 1 ☐ Yes 2 A No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Claims Examiner Social Security Admin. should be filed with and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Katherine Kelly Richard Quinn other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Barbara Quinn Wife 2040 N. Rolling Road; Woodlawn, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Woodlawn Cemetery 7/6/2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility terling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Servici 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter fedisease, or complications that caused shock, or heart failure. List only one cause on each line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Phyllician/ ATHEROSCIERUTE Cardiovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any configuration in the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a gonamouning of burial-transi resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No cate has been signed by the page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 HNo Yes 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

MSKy ap Wnl M' () 29d. Date signed (Month, Day, Year) D0057465 7/1/1

140,1

31. Date filed (Month, Dav. Year State 2011 07 Registrar

5. Ray apaksens

Smith MU 32. Registra s Signa

2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5-703

Raltimore MD 71209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8:33 AM Koss July 02 2011 DLLIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAUTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-28-779 1 □ M 2 🕶 F Director 05-05-Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 33a or 28a-f show important: If them 27 is marked other than "natural", or items be notified at any Injury or other traumatic event, the Medical Examiner must be notified at MD BALTIMORE 1XYes 2 □No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA YORK 6225 21212 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 o Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE OPERATING ROOM TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ULIVER BANKS MARY Elizabeth White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1608 RAMblewood Rd. BALTO, MD. 21239 CASSANDEA HATHONY /DAVEHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/9/11 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BATTIMORE, MD KING PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNCEN SCVS 4905 1101553 BALTO, MD. 21212 YORK ROAD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acute cardiac 1 hour /Medical Due to (or as a consequence of): Examiner 6 months COTOMATY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA 2434 W. BELVEDERE AVENUE 12ALT BEGUM, MD

State Registrar

31. Date filed (Month, Day, Year) JUL 07



BALTIMORE MD - 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John J. Rithman, Sr. Medical 4a. Facility Name (if not institution, give street and number)

Laurel Regional Hosp Examiner 4b. City, Town, or Location of Death Laure George's rince 5. Social Security Number 6. Sex 1**XX**M 2 ☐ F 8. Date of Birth
(Month, Day, Year)
Aug. 27, 1943 If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min Months Washington, D.C 213-40-5858 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Laurel 1 Yes 2X No 10e. Street and Number ö 10f, Zip Code 10g. Citizen of What Country? Funeral 23a20724 USA Rose Street 1 -A items 2 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ō þ 1 Never Married 2 XMarried ☐ Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. "natural", 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th ø Truck Driver Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ည (Unknown) Joe Rithman Florence permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Grace Rithman/Spouse Rose Street, Laurel, MD 20724 1 - A20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/6/2011 Odenton, MD West Arundel Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1, enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, it heart failure. List only one has so on each line. Approximate Interval Between Immediat Cause (Final Cardio-Respiratory Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Myocardial Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examir physician and the burial-transit that initiated events resulting in death) Last Physician/Medical pertension Box 68760 as . IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, Completed 2 ☐ No 3 ☐ Probably XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed or Attending Physician; The 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 Inpatient 2 KER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending 24 hours after death Funeral Director: A 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 46952 completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, Emergency Dept.

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

MD

32. Regist ar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Car1 Stanley Jr :51 Reier, 30 2011 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Months Hours <u>Maryland</u> **Director** 215-32-1987 78 March Usual Residence of Decedent show 10a. State 10b. County with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 ☐ Yes 2X No Maryland Baltimore Lutherville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be r Funeral 12240 Roundwood Road, Unit 802 21093 USA death "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. by 1 Never Married 2 X Married hours after 1 Yes 2 No Specify. Specify: Completed 3 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 of Health and Mental Hygiene.

item 27 is marked other than
other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 02 Blue Cross Insurance Marketing/ Sales Be Mafyland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be ment of Health and Menta Car1 Stanley Reier, Sr. Florence MacKenzie Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Mary Susan Reier/Wife 12240 Roundwood Road, Unit 802, Lutherville, MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Important: If it any injury or c 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State ation 5 Other (Specify) Parkwood Cemetery 7/6/11 Parkville, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1 Inter he disease, or complications the shock, or he it failure. List only one cause of Approximate Interval Between
Onset and Death Immedia e Cau (Final disease consition Physician/ Medical resulting in death) Examiner Esque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transi attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 4 ☐ Pregnant the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Funeral Director, After this certificat, has been signs completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 N Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital
within 24 hours a
To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c, Licens number 29d. Date signed (Month, Day, Year) the completed cause of death (Item 23a) (Type, Print)

30. Name and address of person

JOHN

ST, BALTIMORE